

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

09012										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										09004									
1. DECEASED-NAME (Type or print) First Middle Last MARY VIRGINIA ADAMS										2a. DATE OF DEATH Month 2 Day 1969 Year JUNE										2b. HOUR 7 P. M.									
3. SEX FEMALE					4. RACE WHITE					5. DATE OF BIRTH 4/17/1381					6. AGE (In years last birthday) 88 YRS.					IF UNDER 1 YEAR MONTHS DAYS					IF UNDER 24 HRS. HOURS MIN.				
7a. BIRTHPLACE (State or foreign country) MARYLAND					7b. CITIZEN OF WHAT COUNTRY? U.S.A.					8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH WASHINGTON Md.														
10. CITY OR TOWN OF DEATH RURAL BOONSBORO					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) FAHRNEY KEEDY HOME					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE					12b. KIND OF BUSINESS OR INDUSTRY HOME														
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND					13b. COUNTY WASHINGTON					13c. CITY OR TOWN HAGERSTOWN					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e. STREET AND NUMBER 917 PRESTON RD.									
14. FATHER'S NAME First Middle Last WILLIAM HENRY STOFFER										15. MOTHER'S MAIDEN NAME First Middle Last LILLIE VIRGINIA SIGLER																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO					16b. SOCIAL SECURITY NO. NONE					17. INFORMANT HAGERSTOWN MRS. HAZEL BIKLE MD.																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular</u> 4124 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>neumonitis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 yrs 5 days														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																													
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that (I) (this hospital) attended the deceased from Jan 4, 1969, to June 2, 1969, that (I) (we) last saw the deceased alive on June 2, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE G. W. Lellan M.D.										DEGREE M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED June 4, 1969									
22d. PHYSICIAN'S NAME (Type) G. W. Lellan M.D.										22e. ADDRESS Boonsboro, Md.																			
23a. BURIAL, CREMATION, or other Disposition BURIAL										23b. DATE 4/4/69					23c. NAME OF CEMETERY OR CREMATORY REST HAVEN CEM.					23d. LOCATION (City or Town) (County) (State) HAGERSTOWN WASH. MD.									
24. FUNERAL DIRECTOR W. J. Korman, Hagerstown, Md.										ADDRESS					25a. REC'D BY REGISTRAR JUN 6 1969					25b. REGISTRAR'S SIGNATURE Charles J. J...									

03012

DEPARTMENT OF HEALTH

03012

NAME	AGE	SEX	RACE	DATE OF BIRTH	DATE OF DEATH	PLACE OF BIRTH	PLACE OF DEATH	CAUSE OF DEATH	DIAGNOSIS
JOHN J. BROWN	38	M	WHITE	10/11/1931	10/11/1931	NEW YORK	NEW YORK	HEART DISEASE	HEART DISEASE
MARY J. BROWN	35	F	WHITE	10/11/1931	10/11/1931	NEW YORK	NEW YORK	HEART DISEASE	HEART DISEASE
JOHN J. BROWN	38	M	WHITE	10/11/1931	10/11/1931	NEW YORK	NEW YORK	HEART DISEASE	HEART DISEASE
MARY J. BROWN	35	F	WHITE	10/11/1931	10/11/1931	NEW YORK	NEW YORK	HEART DISEASE	HEART DISEASE

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FOR STATE HEALTH DEPT.

09013

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09005

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print)		First	Middle	Last	2a. DATE KNOWN OF ESTI- DEATH MATED <input type="checkbox"/> 6/20 69		2b. HOUR 4:10
ANNIE		MARY		ADELSBERGER			
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years lost birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD Month Day Year	2d. HOUR 4:10
FEMALE	WHITE	10/11/1877	91 YRS.			6 20 169	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
PENNSYLVANIA		U.S.A.				WASHINGTON Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
HAGERSTOWN		WASHINGTON CO. HOSPITAL		HOUSEWIFE			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
MARYLAND		WASHINGTON		HANCOCK		RURAL 2	
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First Middle Last
EZRA		L. PECK			DOROTHY		COVALT
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
NO		168 16 5726D		WALTER ADELSBERGER HANCOCK MD.		137 HIGH STREET	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metabolic acidoses</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Diabetes</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Hours Years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Arteriosclerosis-generalized</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year HOUR <u>3</u> P.M. 6/19/ 19 69		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 2, Item 18.) Fell at home. Hancock Wash. Md.			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home		21f. LOCATION Street or R.F.D. No. City or Town County State Rt. 2 Hancock, Md.			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE		M.D.			22b. DATE SIGNED		
EXAMINER'S NAME (Type)		Howard N. Weeks			6/23/69		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
BURIAL		6/23/69		TONOLOWAY BAPTIST		RURAL HANCOCK FULTON PA.	
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR DATE	
Richard J. Stone				Hancock, Md.		JUN 26 1969	
						25b. REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1b. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

020013

03000

ANNIE	MARY	ADELBERGER	X
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FEMALE WHITE	10/11/1875	91
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PENNSYLVANIA	U.S.A.	X	WASHINGTON
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HAGERSTOWN	WASHINGTON CO.	HOSPITAL HOUSEWIFE
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MARYLAND	WASHINGTON	HANCOCK	X	RURAL
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ERA	L. PECK	DOROTHY	COVALT
108 10 52500	WALTER ADELBERGER	HANCOCK MD.	137 HIGH STREET

[Handwritten signature]

RURAL	6/23/80	TONCLOWAY BAPTIST	RURAL HANCOCK FULLON PA.
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1978

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR 151
45M - 1/69

09014

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09006

1. DECEASED-NAME (Type or print)		First <i>Mary</i>	Middle <i>Anna</i>	Last <i>Allen</i>	2a. DATE OF DEATH Month <i>June</i> Day <i>14</i> Year <i>1969</i>		2b. HOUR <i>3:55</i> PM		
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>November 3, 1925</i>		6. AGE (In years last birthday) <i>43</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <i>Hagerstown, Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Washington</i> Md.			
10. CITY OR TOWN OF DEATH <i>Hagerstown</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Washington Co. Hospital</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Sales</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Sears-Roebuck</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Washington</i>		13c. CITY OR TOWN <i>Hagerstown</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>334 South St.</i>	
14. FATHER'S NAME First <i>Frank</i> Middle <i>George</i> Last <i>Kramer</i>		15. MOTHER'S MAIDEN NAME First <i>Anna</i> Middle <i>Gale</i> Last <i>Shank</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16b. SOCIAL SECURITY NO. <i>220-16-2465</i>		17. INFORMANT Address <i>20704 G.F. Kramer 11202 Evans Trail Beltsville, Md.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of Liver</i> <i>1978</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>6 mos.</i>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Alcoholism</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>1 pm</i> , 19 <i>67</i> , to <i>74 pm</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>13 pm</i> , 19 <i>62</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Edwin S. Hoachler</i> DEGREE 22d. PHYSICIAN'S NAME (Type) <i>Edwin S. Hoachler</i>				22c. DATE SIGNED <i>6/16/69</i>		22e. ADDRESS <i>Hagerstown Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>6/17/69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Rest Haven Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Hagerstown-Washington Md</i>			
24. FUNERAL DIRECTOR <i>Wm. E. Horst</i> <i>Rest Haven Funeral Chapel</i>		25a. REC'D BY REGISTRAR DATE <i>JUN 19 1969</i>		25b. REGISTRAR'S SIGNATURE <i>James J. ...</i>					

08014

DEPARTMENT OF HEALTH

08014

First Name	Last Name	Address	City	State	Date of Birth	Sex	Age
James	Washington	Washington, D.C.	Washington	D.C.	1927	M	23
James	Washington	Washington, D.C.	Washington	D.C.	1927	M	23
James	Washington	Washington, D.C.	Washington	D.C.	1927	M	23
James	Washington	Washington, D.C.	Washington	D.C.	1927	M	23
James	Washington	Washington, D.C.	Washington	D.C.	1927	M	23
James	Washington	Washington, D.C.	Washington	D.C.	1927	M	23
James	Washington	Washington, D.C.	Washington	D.C.	1927	M	23
James	Washington	Washington, D.C.	Washington	D.C.	1927	M	23
James	Washington	Washington, D.C.	Washington	D.C.	1927	M	23
James	Washington	Washington, D.C.	Washington	D.C.	1927	M	23

[Faint, illegible handwritten text, possibly a signature or address, spanning the bottom half of the page.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

4379

1

<div>09015</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>09007</div>										
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH			2b. HOUR		
First Middle Last IC IA IRENE ANDERSON					Month Day Year JUNE 13 1969			12:35 PM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		
FEMALE		WHITE		4/2/1897		72 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
MARYLAND		U.S.A.				WASHINGTON				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
HAGERSTOWN			WASHINGTON CO. HOSPITAL			HOUSEWIFE		HOME		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND			WASHINGTON		HAGERSTOWN				216 NOTTINGHAM RD.	
14. FATHER'S NAME First Middle Last					15. MOTHER'S MAIDEN NAME First Middle Last					
CANBY STOTTLEMYER					BESSIE SHUFF					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT			Address		
NO			214-09-9261		MR. CLARENCE W. ANDERSON			HAGERSTOWN MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive hemorrhage into Basal ganglia</u> <u>431.9</u> DUE TO, OR AS A CONSEQUENCE OF <u>on right with Diffuse</u> Conditions, if any, which gave rise to immediate cause (a): <u>Cerebral edema</u> stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF <u>Cerebral arteriosclerosis</u> (c) <u>20 yrs</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>17 hrs.</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Diverticular sigmoid colon</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State		
22a. I certify that (I) (this hospital) attended the deceased from <u>June 3</u> , 19 <u>69</u> , to <u>June 13</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>June 13</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Edward W. Ditto</u>					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>6-14-69</u>			
22d. PHYSICIAN'S NAME (Type) EDWARD W. DITTO 111					22e. ADDRESS 217 W. WASHINGTON ST. HAGERSTOWN, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
BURIAL		6/16/69		ROSE HILL CEM.		HAGERSTOWN WASH. MD.				
24. FUNERAL DIRECTOR ADDRESS <u>W. J. Normant, Hagerstown Md</u>					25a. REC'D BY REGISTRAR DATE JUN 19 1969		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

00015

CERTIFICATE OF DEATH

00001

DATE OF DEATH: 10/10/1968 NAME: JAMES H. HARRISON

AGE: 72 SEX: M RACE: W WHITE

PLACE OF BIRTH: ...

CAUSE OF DEATH: ...

DATE OF BURIAL: ...

PLACE OF BURIAL: ...

DATE OF DEATH: 10/10/1968 NAME: JAMES H. HARRISON

AGE: 72 SEX: M RACE: W WHITE

PLACE OF BIRTH: ...

CAUSE OF DEATH: ...

DATE OF BURIAL: ...

PLACE OF BURIAL: ...

DATE OF DEATH: 10/10/1968 NAME: JAMES H. HARRISON

AGE: 72 SEX: M RACE: W WHITE

PLACE OF BIRTH: ...

CAUSE OF DEATH: ...

DATE OF BURIAL: ...

PLACE OF BURIAL: ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
09016									
09008									
1. DECEASED-NAME (Type or print)			First Middle Last THELMA LUCILLE BALSLEY			2a. DATE OF DEATH Month Day Year JUNE 12 69		2b. HOUR M	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH JUNE 17, 1905		6. AGE (In years last birthday) 63 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH WASH WASHINGTON		Md.	
10. CITY OR TOWN OF DEATH HAGERSTOWN		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) CONVALESCENT HOME JACKSON		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) RETIRED PRESSER		12b. KIND OF BUSINESS OR INDUSTRY TROY LAUNDRY			
13a. USUAL RESIDENCE (Where deceased admission) STATE MARYLAND		13b. COUNTY WASHINGTON		13c. CITY OR TOWN HAGERSTOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 242 S POTOMAC STREET	
14. FATHER'S NAME First Middle Last EMORY McCLEARY			15. MOTHER'S MAIDEN NAME First Middle Last CLARA SMITH						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 214-09-4875		17. INFORMANT GEORGE J BALSLEY		242 Address S POTOMAC ST. HAGERSTOWN, MARYLAND	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF <u>sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 Yrs</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Hyperlipidemia, cardiac</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (the hospital) attended the deceased from <u>1 Aug 69</u> , to <u>date</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>2 June 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Richard T. Binford</u>		22c. DATE SIGNED 6/13/69		22d. PHYSICIAN'S NAME (Type) RICHARD T BINFORD		22e. ADDRESS 1135 POTOMAC AVE., HAGERSTOWN, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 6/14/68		23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY		23d. LOCATION (City or Town) (County) (State) HAGERSTOWN, WASHINGTON, MD.			
24. FUNERAL DIRECTOR <u>Charles M. Rouse</u>				ADDRESS HAGERSTOWN, MARYLAND		25a. REC'D BY REGISTRAR JUN 17 1969		25b. REGISTRAR'S SIGNATURE <u>Charles M. Rouse</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
09017					09009				
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) First Middle Last KARL LEON BARR					2a. DATE OF DEATH JUNE Month 28 Day 1969 Year			2b. HOUR P.M. 2.45	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 9/22/1895		6. AGE (In years last birthday) 73 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH WASHINGTON		Md.	
10. CITY OR TOWN OF DEATH HAGERSTOWN		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WASHINGTON CO. HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) SALES SUPERVISOR		12b. KIND OF BUSINESS OR INDUSTRY ELECTRIC CO.			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. CITY OR TOWN WASHINGTON HAGERSTOWN		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 929 MULBERRY AVE.			
14. FATHER'S NAME First Middle Last CIARENCE ALFRED BARR		15. MOTHER'S MAIDEN NAME First Middle Last CORA ELIZABETH DOWLER							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) NO		16b. SOCIAL SECURITY NO. 214-10-4629		17. INFORMANT Address MRS. MILDRED WOLF HAGERSTOWN MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>403X</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Nephrosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Generalized arteriosclerosis</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 wk</u> <u>unk</u> <u>unk</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Dissecting aortic aneurysm with hemorrhage</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Jan 31, 1953, to June 28, 1969, that (I) (we) last saw the deceased alive on June 28, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>L. L. Parker Jr</u>				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 6/30/69			
22d. PHYSICIAN'S NAME (Type) L. L. Parker Jr MD				22e. ADDRESS 145 W. Washington St Hagerstown, Md					
23a. BURIAL, CREMATION, or other disposition BURIAL		23b. DATE 7/1/69		23c. NAME OF CEMETERY OR CREMATORY REST HAVEN CEM.		23d. LOCATION (City or Town) (County) (State) HAGERSTOWN WASH. MD.			
24. FUNERAL DIRECTOR <u>W. J. Normant, Hagerstown, Md</u>				ADDRESS		25a. REC'D BY REGISTRAR JUL 7 1969		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
09018											
CERTIFICATE OF DEATH											
09010											
1. DECEASED-NAME (Type or print) ELIZABETH HARRIETT BEAHM						2a. DATE OF DEATH Month June Day 1 , Year 1969		2b. HOUR M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH Sept. 27, 1906		6. AGE (In years last birthday) 62 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington					
10. CITY OR TOWN OF DEATH Sandy Hook		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Residence				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Practical Nurse			12b. KIND OF BUSINESS OR INDUSTRY Hospital		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Sandy Hook		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Old Rt. 340			
14. FATHER'S NAME First Middle Last Tilghman Augustus Holder				15. MOTHER'S MAIDEN NAME First Middle Last Alice May Johnson							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. 218-30-8910		17. INFORMANT Edwin J. Holder Address R.F.D. # 2, Knoxville, Md. 21758							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Instantly Unknown	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 1953 , 19____, to 1969 , 19____, that (I) (we) lost saw the deceased alive on 5-1- 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE L. Mildred Williams M.D. DEGREE						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 6-3-69			
22d. PHYSICIAN'S NAME (Type) L. MILDRED WILLIAMS M.D.						22e. ADDRESS CHARLES TOWN, W.VA.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6/4/69		23c. NAME OF CEMETERY OR CREMATORY Old Brethren Cemetery				23d. LOCATION (City or Town) (County) (State) Brownsville, Wash., Md.			
24. FUNERAL DIRECTOR Donald Eckler ADDRESS Harpers Ferry, WEST Va.				25a. REC'D BY REGISTRAR JOHN 6 1969		25b. REGISTRAR'S SIGNATURE Charles Judge					

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OFFICIAL RECORD

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH			2b. HOUR	
JACOB CHALMERS BEAVER					JUNE 23, 1969			7:30 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR	
MALE		Caucasian		25 Nov 1887		90 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		12b. KIND OF BUSINESS OR INDUSTRY	
Franklin Co. Maryland		USA.				Washington Co.		General	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)					
HAGERSTOWN		GARLOCK NURSING HOME		Carpenter					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md.		Wash.		Hagerstown		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		847 Florida Ave.	
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME				
GEROME BEAVER					MARY DAVIS				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)					16b. SOCIAL SECURITY NO.		17. INFORMANT		
NO					203-10-7364		SON. George Beaver 241 Winter St Hagerstown, Md		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) cerebral thrombosis									1 day
4339 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b) cerebral arteriosclerosis									unk.
DUE TO, OR AS A CONSEQUENCE OF									
(c) arteriosclerosis, general									unk.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)									
Chronic bronchitis, pulmonary fibrosis, arteriosclerosis, heart disease									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town	
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>									
22a. I certify that (I) (this hospital) attended the deceased from 21 May 1969, to 23 June 1969, that (I) (we) lost the deceased alive on 23 June 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE					ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED
Clovie M. Snyder MD					<input checked="" type="checkbox"/>				23 June 69
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
CLOVIS M. SNYDER					1067 Potomac St Hagerstown, Md				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)	
Burial		6/26/69		Beautiful View		Wash. Co., Md.			
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
A.E. Munch - Greencastle, Pa.					JUN 25 1969		Charles Judge		

OF THE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
09020													
CERTIFICATE OF DEATH													
09012													
1. DECEASED-NAME (Type or print) Catherine Ann Benner						2a. DATE OF DEATH Month June Day 11 Year 1969			2b. HOUR				
3. SEX Female		4. RACE White		5. DATE OF BIRTH July 14, 1938			6. AGE (In years last birthday) 30 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) Hagerstown, Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington							
10. CITY OR TOWN OF DEATH Hagerstown				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington Co. Hospital				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Machine Operator			12b. KIND OF BUSINESS OR INDUSTRY Shoe Mfg.		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland				13b. COUNTY Washington		13c. CITY OR TOWN Smithsburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Route # 2			
14. FATHER'S NAME First Middle Last Elmer Ellsworth Long, Sr.						15. MOTHER'S MAIDEN NAME First Middle Last Freda Mildred Roser							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)				16b. SOCIAL SECURITY NO. 214-094113		17. INFORMANT Address Mr. Robert L. Benner R # 2 Smithsburg, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Leukemia 2070 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
MEDICAL CERTIFICATION													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 1969				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from June 11, 1969 , to June 12, 1969 , that (I) (we) last saw the deceased alive on June 11, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE G. W. LeVan M.D.						22c. DATE SIGNED 6-13-69		22d. PHYSICIAN'S NAME (Type) G. W. LeVan					
22e. ADDRESS Boonslow, Ind.													
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE 6/15/69		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery				23d. LOCATION (City or Town) (County) (State) Hagerstown-Washington-Md.			
24. FUNERAL DIRECTOR Wm. C. Hoff Rest Haven Funeral Chapel						ADDRESS Hagerstown, Md.		25a. REC'D BY REGISTRAR JUN 17 1969		25b. REGISTRAR'S SIGNATURE Judge			

1950

CERTIFICATE OF MARRIAGE

00000

On this day of the month of

at the County of

State of

between

and

both of legal age

and

have

entered into the bonds of matrimony

in accordance with the rites and ceremonies

of the Christian religion

and the laws of the State of

and the County of

and the City of

and the Parish of

and the Precinct of

and the Ward of

and the Block of

and the Lot of

09021

09013

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) Domenico		First		Middle		Last		2a. DATE OF DEATH Month 6 Day 6 Year 1969			2b. HOUR 2:05 A.M.		
3. SEX Male		4. RACE White		5. DATE OF BIRTH Feb. 19 1893			6. AGE (In years last birthday) 76 YRS.		IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS. HOURS MIN		
7a. BIRTHPLACE (State or foreign country) Italy		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington Md.							
10. CITY OR TOWN OF DEATH Williamsport				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Williamsport Sanitarian 154 N. Artisan St. Wmsport, Md.				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) LABORER			12b. KIND OF BUSINESS OR INDUSTRY MFG.		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md				13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 513 Liberty Street			
14. FATHER'S NAME Camillo				First		Middle		Last		15. MOTHER'S MAIDEN NAME Santo First Middle Last DiFrazio			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No (If yes give war or dates of service)				16b. SOCIAL SECURITY NO. 216-61-1412		17. INFORMANT Mrs. Rocco Zappacosta 103 N Address CLEVELAND AVE. HAGERSTOWN, MD.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure 4123 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 wk	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Chronic Emphysema, Rheumatoid Arthritis													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 1953 , 19__, to 6/6 , 19 69 , that (I) (we) last saw the deceased alive on 6/5/69 , 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Robert V L Campbell								DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED JUNE 6, 1969	
22d. PHYSICIAN'S NAME (Type) ROBERT V L CAMPBELL								22e. ADDRESS 145 W WASHINGTON ST., HAGERSTOWN, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE JUNE 9 1969		23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY			23d. LOCATION (City or Town) (County) (State) HAGERSTOWN WASHINGTON MD.				
24. FUNERAL DIRECTOR Charles M. Rieger Hagerstown Maryland								25a. REC'D BY REGISTRAR JUN 11 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

(1)

Robert M. Campbell

1932

Robert M. Campbell

1932

5679
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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09022

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09014

1. DECEASED-NAME (Type or print) First Middle Last DOLLY ROMAINE BURCKER			2a. DATE OF DEATH Month Day Year June 10 1969			2b. HOUR 7. M					
3. SEX Female		4. RACE White		5. DATE OF BIRTH Dec. 18 1926		6. AGE (In years last birthday) 42 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington			Md.		
10. CITY OR TOWN OF DEATH Hagerstown			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Wash County Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Waitress			12b. KIND OF BUSINESS OR INDUSTRY Restaurant		
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE Maryland			13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 651 Potomac St		
14. FATHER'S NAME First Middle Last Charles E. Itnyre Sr			15. MOTHER'S MAIDEN NAME First Middle Last Anna Florence Gross								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No --			16b. SOCIAL SECURITY NO. --		17. INFORMANT Address Mrs Anna Frizell 651 Potomac Ave						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 5679 IMMEDIATE CAUSE (a) Peritonitis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION 3 June 69		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Peritonitis				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HDUR A.M. Month Day Year P.M. 19		21c. HDW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (his hospital) attended the deceased from 24 May 1969 , to 10 June 1969 , that (I) (we) saw the deceased alive on 10 June 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Frank E Brumback MD						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 13 June 69			
22d. PHYSICIAN'S NAME (Type) Frank E Brumback						22e. ADDRESS 119 King St Hagerstown Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6/13/69		23c. NAME OF CEMETERY DR CREMATORY Boonsboro Cemetery		23d. LOCATION (City or Town) (County) (State) Boonsboro Wash Co Md					
24. FUNERAL DIRECTOR Hagerstown Md. ADDRESS Andrew K. Coffman Funeral Home Inc						25a. REC'D BY REGISTRAR JUN 10 1969		25b. REGISTRAR'S SIGNATURE William J. Judge			

08032

RECEIVED BY MAIL

June 1, 1950

BRANCH

NEW YORK

DOES

Dec. 18, 1950

Washington

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Dec. 18, 1950

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

4123

09023

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

09015

1. DECEASED-NAME (Type or print) James R. Canfield			2a. DATE OF DEATH Month June Day 19 , Year 1969		2b. HOUR M
3. SEX Male	4. RACE White	5. DATE OF BIRTH Sept. 3, 1879		6. AGE (In years last birthday) 89 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) West Virginia	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Washington Md.		
10. CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington County Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Carpenter		12b. KIND OF BUSINESS OR INDUSTRY Building	
13a. USUAL RESIDENCE (Where deceased admission) STATE Maryland	13b. CITY OR TOWN Washington	13c. CITY OR TOWN Hagerstown	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 608 Potomac Ave.	
14. FATHER'S NAME First Middle Last David B. Canfield		15. MOTHER'S MAIDEN NAME First Middle Last Luverna Ann Everett			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 218-12-5005	17. INFORMANT Mr. J. Willard Canfield Hagerstown, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4123 Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15yr					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Chronic Pulmonary emphysema					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to 6/19 , 19 69 , that (I) (we) last saw the deceased alive on 6/19 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE William O. Rexrode M.D.		DEGREE M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type) William O. Rexrode M.D.		22e. ADDRESS Hagerstown, MD. 145 S. Prospect St.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE June 23, 1969	23c. NAME OF CEMETERY OR CREMATORY Rosedale Cemetery	23d. LOCATION (City or Town) (County) (State) Martinsburg, W. Va. Berkeley Co.		
24. FUNERAL DIRECTOR ADDRESS Albert L. Leaf Williamsport, Maryland			25a. REC'D BY REGISTRAR DATE JUN 25 1969	25b. REGISTRAR'S SIGNATURE Charles Judge	

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OFFICE OF THE

UNITED STATES DEPARTMENT OF THE INTERIOR

Section of Lands

and

Water

Department of the Interior

Washington, D.C.

1911-1912

[Faint signature]

[Faint signature]

William C. Barry, Jr.

Assistant Secretary

June 27, 1912

Chief of the Bureau of Land Management

U.S. Department of the Interior

Washington, D.C.

Very truly yours,

1579

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

09024		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		09016	
Item #5, Film GL13		6/12/69 km		CERTIFICATE OF DEATH	
1. DECEASED-NAME (Type or print) First Middle Last EARL A. CLINGERMAN			2a. DATE OF DEATH Month Day Year JUNE 3, 1969		2b. HOUR 6:00 P
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 1898 NOVEMBER 4 1889 70	
6. AGE (In years last birthday) YRS. 70		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH WASHINGTON Md.	
7a. BIRTHPLACE (State or foreign country) PENNA.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		10. CITY OR TOWN OF DEATH HAGERSTOWN	
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WASHINGTON CO. HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) TRUCK DRIVER		12b. KIND OF BUSINESS OR INDUSTRY TRUCKING	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before death) STATE MARYLAND		13b. CITY OR TOWN WASHINGTON HAGERSTOWN		13c. STREET AND NUMBER 195 W. WILSON BLVD.	
14. FATHER'S NAME First Middle Last MORGAN CLINGERMAN		15. MOTHER'S MAIDEN NAME First Middle Last GERTIE POTTER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) NO		16b. SOCIAL SECURITY NO. 219 12 0756		17. INFORMANT Address IRA CLINGERMAN ARTEMAS PENNA.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Pancreas</u> 1579 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 mo
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>1-26-</u> , 19 <u>67</u> , to <u>6-3-</u> , <u>69</u> , that (I) (we) last saw the deceased alive on <u>6-3-69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>A. E. W. Little Jr.</u>		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>6-5-69</u>	
22d. PHYSICIAN'S NAME (Type) <u>A. E. W. Little Jr.</u>		22e. ADDRESS <u>515 W. Washington Hagerstown Pa</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 6/16/69		23c. NAME OF CEMETERY OR CREMATORY FAIRVIEW CHRISTIAN	
24. FUNERAL DIRECTOR <u>Richard J. Stone Hancock, Md.</u>		25a. REC'D BY REGISTRAR <u>DAVIN</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
23d. LOCATION (City or Town) (County) (State) BEDFORD CO., PENNA					

10028

UNITED STATES DEPARTMENT OF JUSTICE

6:00 PM JUNE 2, 1963 A. CLINGERMAN EARL

MALE WHITE NOVEMBER 1, 1909

PENNA. U.S.A. X WASHINGTON

HAGERSTOWN WASHINGTON CO. HOSPITAL TRUCK DRIVER TRUCKING

MARYLAND WASHINGTON HAGERSTOWN X 135 N. WILSON BLVD.

MORGAN CLINGERMAN GERTIE BETTE

NO 10 12 0000 18A CLINGERMAN GERTIE BETTE, PENNA.

RECEIVED CO. PENNA. 06/03/63

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

09025

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09017

1. DECEASED-NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF DEATH				2b. HOUR			
MAY		SOPHONIA		COLEMAN		JUNE 2 1969				10 AM					
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD				2d. HOUR			
FEMALE	WHITE	DEC. 4, 1890	78 YRS.	MONTHS		DAYS		JUNE 2 1969				5 PM			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH						Md.			
MD.		U.S.A.				WASHINGTON									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY									
HAGERSTOWN		506 SHERWOOD DRIVE		HOMEMAKER		AT HOME									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER							
MD		WASHINGTON		HAGERSTOWN		YES <input type="checkbox"/> NO <input type="checkbox"/>		506 SHERWOOD DRIVE HAGERSTOWN, MD.							
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First		Middle		Last	
UNKNOWN								UNKNOWN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
NO				215-09-9029		ETHEL L. BOUBLITZ		506 SHERWOOD DR. HAGERSTOWN, MD.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a) <u>Coronary occlusion</u>												Turned			
DUE TO, OR AS A CONSEQUENCE OF															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.															
(b) <u>Arterio sclerotic vascular Dis.</u>												25 years			
DUE TO, OR AS A CONSEQUENCE OF															
(c) <u>Coronary atherosclerosis</u>															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?							
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
				HOUR A.M. 19 P.M.											
21d. INJURY OCCURRED				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State							
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>															
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE <u>Edward W. Ditto III</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED							
EXAMINER'S NAME (Type) EDWARD W. DITTO, 111 M.D. 217 W. WASH. ST., HAGERSTOWN, MD.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				JUNE 3, 1969							
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>											
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)			
BURIAL				JUNE 4, 1969				REST HAVEN CEMETERY				HAGERSTOWN WASH. MD.			
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
Charles M. Rauter				HAGERSTOWN, MD.				JUN 5 1969				Charles M. Rauter			

2500

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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09026		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				09018	
1. DECEASED-NAME (Type or print)				2a. DATE OF DEATH		2b. HOUR	
First <i>Florence</i>		Middle <i>Emma</i>		Last <i>Cosey</i>		Month <i>June</i> Day <i>1</i> Year <i>1969</i>	
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>September 17, 1894</i>		6. AGE (In years last birthday) <i>74</i> YRS.	
7a. BIRTHPLACE (State or foreign country) <i>Dayton, Va.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Washington</i>	
10. CITY OR TOWN OF DEATH <i>Hagerstown</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Washington Co. Hospital</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Washington</i>		13c. CITY OR TOWN <i>Hagerstown</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First <i>Willis</i> Middle <i>James</i> Last <i>Shifflett</i>		15. MOTHER'S MAIDEN NAME First <i>Sarah</i> Middle <i>Edith</i> Last <i>Mumaw</i>		13e. STREET AND NUMBER <i>231 Alexander St.</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16b. SOCIAL SECURITY NO. <i>217-10-2719D</i>		17. INFORMANT Address <i>Trenton R. Juell 303 W. Par Orlando, Fla. 32804</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4123 Congestive Heart Failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerotic Heart Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Dermoid Cyst Rt Ovary & Carcinomatous changes</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> <i>10 years</i> <i>6 mos</i>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION <i>5/25/69</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Carcinoma of ovary</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>May 23, 1969</i> to <i>June 1, 1969</i> , that (I) (we) saw the deceased alive on <i>June 1, 1969</i> , and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>John A. Moran M.D.</i>				22c. DATE SIGNED <i>6/2/69</i>		22d. PHYSICIAN'S NAME (Type) <i>JOHN A. MORAN M.D.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>6/4/69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Rest Haven Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Hagerstown-Washington Md.</i>	
24. FUNERAL DIRECTOR <i>Wm. C. Hunt</i>				25a. REC'D BY REGISTRAR <i>JUN 5 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

00030

RECORD OF DEATH

Place of Birth Date of Birth Sex Color

White Male October 1, 1904

Occupation Age at Death Cause of Death

Unemployed 37 Heart Disease

Place of Death Date of Death

White Male 37

1941-10-10 Death at home, New York City

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[Faint, illegible handwritten text]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

09027

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

09019

1. DECEASED-NAME (Type or print) HELEN ANN COST			2a. DATE OF DEATH Month 8 Day 69 Year 1969			2b. HOUR 1:30 a.m. M				
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH JUNE 29, 1883		6. AGE (In years last birthday) 85 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0 IF UNDER 24 HRS. HOURS 0 MIN 0		
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH WASHINGTON				
10. CITY OR TOWN OF DEATH RURAL HAGERSTOWN			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ROUTE #3			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOMEMAKER			12b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND			13b. COUNTY WASHINGTON		13c. CITY OR TOWN HAGERSTOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER ROUTE #3	
14. FATHER'S NAME First THOMAS Middle H Last REEL			15. MOTHER'S MAIDEN NAME First MARY Middle GRICE Last GRICE							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) NO (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 216-38-0768		17. INFORMANT Address ROUTE #3 HAGERSTOWN, MARYLAND SHERIDAN REEL					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) uremia 4123 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arterio sclerotic heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) slavation									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH about 1 week any standing about 1 week	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) aged and cachexia										
19a. DATE OF OPERATION 6/10/69		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. 19 Month 6 Day 10 Year 1969 P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. 120 W MAIN, SHARPSBURG, MARYLAND City or Town SHARPSBURG County WASHINGTON State MD.						
22a. I certify that (I) (this hospital) attended the deceased from 1968 , 19 6/10 , 19 69 , that (I) (we) last saw the deceased alive on 6/10 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Charles M. Rangan		DEGREE MD		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 6/9/69				
22d. PHYSICIAN'S NAME (Type) RIZALITO AMARILLO		22e. ADDRESS 120 W MAIN, SHARPSBURG, MARYLAND								
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 6/10/69		23c. NAME OF CEMETERY OR CREMATORY MT. VIEW CEMETERY			23d. LOCATION (City or Town) (County) (State) SHARPSBURG, WASHINGTON, MD.			
24. FUNERAL DIRECTOR Charles M. Rangan		ADDRESS HAGERSTOWN, MARYLAND			25a. REC'D BY REGISTRAR DATE JUN 12 1969		25b. REGISTRAR'S SIGNATURE Charles M. Rangan			

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

09028

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09020

1. DECEASED-NAME (Type or Print)			First <i>Hilda</i>	Middle <i>Armatha</i>	Last <i>Cromer</i>	2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year <i>6/14 1969</i>			2b. HOUR <i>5</i> a.m.	
3. SEX <i>Female</i>	4. RACE <i>White</i>	5. DATE OF BIRTH <i>January 10, 1912</i>	6. AGE (In years last birthday) <i>57</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year <i>6 14 19 69</i>		2d. HOUR <i>6</i> a.m.
7a. BIRTHPLACE (State or foreign country) <i>Waynesboro, Pa.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Washington</i>				Md.
10. CITY OR TOWN OF DEATH <i>Hagerstown</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>64 1/2 W. Franklin St.</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Barmaid</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Tavern</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>			13b. COUNTY <i>Washington</i>		13c. CITY OR TOWN <i>Hagerstown</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>64 1/2 W. Franklin St.</i>	
14. FATHER'S NAME First Middle Last <i>Daniel (m.m.) Slick</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>Clara Elizabeth Myers</i>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>				
16b. SOCIAL SECURITY NO. <i>217-28-2289</i>			17. INFORMANT ADDRESS <i>Hagerstown, Md.</i> <i>Mrs. Dorothy Domer 639 N. Mulberry St.</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cirrroses of liver with hemorrhage</i> <i>5719</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Chronic schism alcoholism</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Hours</i> <i>Years</i>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <i>Howard N. Weeks</i>			EXAMINER'S NAME (Type) <i>Howard N. Weeks</i>			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			22b. DATE SIGNED <i>6/16/69</i>	
ADDRESS (Street, city, town, or county) <i>Washington Co.</i>										
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE <i>6/18/69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cemetery</i>			23d. LOCATION (City or Town) (County) (State) <i>Greencastle-Franklin-Penna.</i>		
24. FUNERAL DIRECTOR <i>Wm. C. Koss</i> <i>Rest Haven Funeral Chapel Hagerstown, Md.</i>						25a. REC'D BY REGISTRAR <i>JUN 19 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

02021

GENERAL TARIFF - AGRICULTURE OF DEATH

00002

1911

NAME	RESIDENCE	OCCUPATION	DATE OF DEATH	CAUSE OF DEATH	AGE
JAMES	JAMES	JAMES	JAMES	JAMES	JAMES
JAMES	JAMES	JAMES	JAMES	JAMES	JAMES
JAMES	JAMES	JAMES	JAMES	JAMES	JAMES
JAMES	JAMES	JAMES	JAMES	JAMES	JAMES
JAMES	JAMES	JAMES	JAMES	JAMES	JAMES
JAMES	JAMES	JAMES	JAMES	JAMES	JAMES
JAMES	JAMES	JAMES	JAMES	JAMES	JAMES
JAMES	JAMES	JAMES	JAMES	JAMES	JAMES
JAMES	JAMES	JAMES	JAMES	JAMES	JAMES
JAMES	JAMES	JAMES	JAMES	JAMES	JAMES
JAMES	JAMES	JAMES	JAMES	JAMES	JAMES
JAMES	JAMES	JAMES	JAMES	JAMES	JAMES
JAMES	JAMES	JAMES	JAMES	JAMES	JAMES
JAMES	JAMES	JAMES	JAMES	JAMES	JAMES
JAMES	JAMES	JAMES	JAMES	JAMES	JAMES
JAMES	JAMES	JAMES	JAMES	JAMES	JAMES
JAMES	JAMES	JAMES	JAMES	JAMES	JAMES
JAMES	JAMES	JAMES	JAMES	JAMES	JAMES
JAMES	JAMES	JAMES	JAMES	JAMES	JAMES
JAMES	JAMES	JAMES	JAMES	JAMES	JAMES
JAMES	JAMES	JAMES	JAMES	JAMES	JAMES
JAMES	JAMES	JAMES	JAMES	JAMES	JAMES
JAMES	JAMES	JAMES	JAMES	JAMES	JAMES
JAMES	JAMES	JAMES	JAMES	JAMES	JAMES
JAMES	JAMES	JAMES	JAMES	JAMES	JAMES
JAMES	JAMES	JAMES	JAMES	JAMES	JAMES
JAMES	JAMES	JAMES	JAMES	JAMES	JAMES
JAMES	JAMES	JAMES	JAMES	JAMES	JAMES
JAMES	JAMES	JAMES	JAMES	JAMES	JAMES

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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09029				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				09021					
1. DECEASED-NAME (Type or print)				First	Middle	Lost	2a. DATE OF DEATH Month Day Year				2b. HOUR		
JULIA				GRAND	BERRY	CROSS	JUNE 30 1969				2:20 A.M.		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		
FEMALE		W		JULY 5, 1977			91 YRS.						
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH							
ALABAMA		U.S.A.				Washington - HAGERSTOWN Md.							
1D. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY	
Williamsport Md.				154 N. ARTIZAN ST -				Housewife					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER					
Maryland Montgomery				Gaithersburg				16 Peony Drive					
14. FATHER'S NAME				First	Middle	Lost	15. MOTHER'S MAIDEN NAME				First	Middle	Lost
Robert				Lee	Ellis		Emma				Jernigan		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown				16b. SOCIAL SECURITY NO.		17. INFORMANT							
No				None		Mr. Albert H. Cross Pawtuckett, R.I.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> <u>431.9</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Atherosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>none</u>													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>2.5.</u> , 19 <u>64</u> , to <u>6.30</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>6.15.69</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE				DEGREE				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED			
<u>[Signature]</u>										6.30.69			
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS									
M.E. Byrkit M.D.				28 W. Potomac St. Williamsport, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)			
Burial				July 3, 1969		Pleasant Home Cemetery Andalusia, Covington, Alabama							
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE					
Albert L. Leaf Williamsport, Md.				JUL 2 1969				<u>[Signature]</u>					

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18 & 22a Film 414 Maryland State Department of Health
6-26-69 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09030

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09022

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year			2b. HOUR		
Mary Elizabeth Davis						6/19 1969			5:05 A.M.		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year			2d. HOUR
F	W	4/11/52	17 YRS.					6/19/69			5:05 A.M.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Penna.		U. S. A.				Washington					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Hagerstown			Wash. Co. Hospital			waitress			restaurant		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER		
Penna.			Bedford		Bedford				RFD 4		
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last							
Marvin F. Davis, Sr.				Elizabeth White							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS						
X					Marvin F. Davis, Sr., Bedford, Pa.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal aspiration</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Subarachnoid hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF <u>Ruptured aneurysm</u> (Circumstances under investigation by city police and also pending final autopsy result)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE		Howard N. Weeks, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type)						ADDRESS (Street, city, town, or county)		22b. DATE SIGNED		6/19/69	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
burial		6-22-69		Pleasant Union Cem.		Bedford Co., Penna.					
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Conner Funeral Home, Everett, Penna.						Date 23 1969		[Signature]			

02025

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Washington

U. S. A.

Young

Restaurant

Whish. Co. Hospital

Le. system

1000

Bedford

Penn.

Albany, N.Y.

Arthur E. Davis, Jr.

Arthur E. Davis, Jr., Bedford, Pa.

1000

Bedford

Pa.

1000

Bedford

Pa.

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Bedford

Pa.

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Bedford

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Bedford

Pa.

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Bedford

Pa.

Bedford Co., Penn.

Pleasant Union Com.

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Bedford, Penn.

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15 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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2

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
09031		CERTIFICATE OF DEATH						09023			
1. DECEASED-NAME (Type or print)			First Mary			Middle KEESEY			Last Dempwolf		
3. SEX Female			4. RACE Caucasian			5. DATE OF BIRTH 3/22/98			20. DATE OF DEATH Month 6 Day 26 Year 69		
70. BIRTHPLACE (State or foreign country) Pennsylvania			7b. CITIZEN OF WHAT COUNTRY? United States			B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			2b. HOUR 6 a M		
10. CITY OR TOWN OF DEATH Hagerstown, Md.			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Brook Lane Psychiatric Center			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Unemployed			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived; if institution: Residence before admission) STATE Pennsylvania			13b. COUNTY York			13c. CITY OR TOWN York			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME First Middle Last WILLIAM S STAIR			15. MOTHER'S MAIDEN NAME First Middle Last HELEN KEESEY			13e. STREET AND NUMBER 904 S. George Street					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unknown			16b. SOCIAL SECURITY NO. 188-36-4668			17. INFORMANT Address Work, Pa.			17. INFORMANT Address Work, Pa.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular fibrillation</u> 4122 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>chronic atrial fibrillation and CHF</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>hypertensive arteriosclerotic heart disease</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>June 20</u> , 1969, to <u>June 26</u> , 1969, that (I) (we) last saw the deceased alive on <u>June 26</u> , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Paul Saraduke, M.D.			22c. DATE SIGNED 6/26/69			22d. PHYSICIAN'S NAME (Type) Paul Saraduke, M.D.			22e. ADDRESS Brook Lane Psychiatric Center, Hagerstown		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE 6/28/69			23c. NAME OF CEMETERY OR CREMATORY PROSPECT HILL CEMETERY			23d. LOCATION (City or Town) (County) (State) YORK, YORK, PENNSYLVANIA		
24. FUNERAL DIRECTOR Charles M. Reuge			ADDRESS HAGERSTOWN, MARYLAND			25a. REC'D BY REGISTRAR DATE JUN 30 1969			25b. REGISTRAR'S SIGNATURE Charles Judge		

FOR STATE
HEALTH DEPT.

09032

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09024

1. DECEASED-NAME (Type or Print) John Grover Dorman			2a. DATE KNOWN OF DEATH Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/> June 24, 1969			2b. HOUR 2:15 P.M.			
3. SEX Male	4. RACE White	5. DATE OF BIRTH August 1, 1908	6. AGE (In years lost birthday) 60 YRS.	IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>	IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN <input type="checkbox"/>	2c. DATE PRONOUNCED DEAD Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/> June 24, 1969			2d. HOUR 2:30 P.M.
7a. BIRTHPLACE (State or foreign country) Harrisonburg, Va.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington Md.			
10. CITY OR TOWN OF DEATH Boonsboro		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Rfd. 1		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Farmer		12b. KIND OF BUSINESS OR INDUSTRY Farming			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Boonsboro		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Rfd. 1	
14. FATHER'S NAME First Frank Middle Dorman Last Dorman			15. MOTHER'S MAIDEN NAME First Florence Middle Lambert Last Lambert						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No.		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 217-32-7162		17. INFORMANT ADDRESS Mrs. Ethel Dorman, Rfd. 1, Boonsboro, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 4100 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Arteriosclerotic Cardiac Disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Few minutes Several years									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. <input type="checkbox"/> P.M. <input type="checkbox"/> 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Dr. E. W. Ditto, Jr.		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Dr. E. W. Ditto, Jr.		215 W. Washington St.,		Hagerstown, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6-27-69		23c. NAME OF CEMETERY OR CREMATORY Rohrersville Cemetery		23d. LOCATION (City or Town) (County) (State) Rohrersville, Wash. Co., Md.			
24. FUNERAL DIRECTOR John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.				25a. REC'D BY REGISTRAR DATE JUN 27 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-13. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

08032

08032

FOR DATA
HEALTH DEPT



Medical Examination Report
Name: [illegible]
Date: [illegible]
Age: [illegible]
Sex: [illegible]
Occupation: [illegible]
Address: [illegible]
City: [illegible]
State: [illegible]
Zip: [illegible]
Physician: [illegible]
Specialist: [illegible]
Referral: [illegible]
Examination: [illegible]
Findings: [illegible]
Diagnosis: [illegible]
Recommendations: [illegible]
Signature: [illegible]
Date: [illegible]

1830

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

09033

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09025

1. DECEASED-NAME (Type or print) Sarah Ruth Dutrow			2a. DATE OF DEATH Month Day Year June 16, 1969			2b. HOUR 12:55 PM					
3. SEX Female		4. RACE White		5. DATE OF BIRTH 2/16/02		6. AGE (In years last birthday) 67 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH WASHINGTON COUNTY Md.					
10. CITY OR TOWN OF DEATH HAGERSTOWN		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WESTERN MD. STATE HOSPITAL				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Seamstress			12b. KIND OF BUSINESS OR INDUSTRY store clothing		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 619 N. Mulberry St.			
14. FATHER'S NAME First Middle Last Sumner Keller			15. MOTHER'S MAIDEN NAME First Middle Last Mary Summers			Address Hagerstown, Md.					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. 214-09-0793		17. INFORMANT Mrs. Doris Smith, 619 N. Mulberry St.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the ovaries with metastases to</u> <u>1830</u> DUE TO, OR AS A CONSEQUENCE OF <u>abdominal cavity</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause } (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (the hospital) attended the deceased from <u>June 10, 1969</u> , to <u>June 16, 1969</u> , that (I) (we) last saw the deceased alive on <u>June 16, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.											
22b. SIGNATURE Chong Choon Han				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 6/16/69					
22d. PHYSICIAN'S NAME (Type) Chong Choon Han, M.D.				22e. ADDRESS Western Maryland State Hospital, 1500 Pennsylvania Ave., Hagerstown, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6/18/69		23c. NAME OF CEMETERY OR CREMATORY Reformed Cemetery			23d. LOCATION (City or Town) (County) (State) Middletown, Fred., Md.				
24. FUNERAL DIRECTOR Gladhill Company, Middletown, Md.				ADDRESS		25a. REC'D BY REGISTRAR JUN 19 1969		25b. REGISTRAR'S SIGNATURE			

63920

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

09034

09026

1. DECEASED-NAME (Type or print) Nettie Blanche Emmert			2a. DATE OF DEATH Month June Day 22 Year 1969			2b. HOUR 10:00P M				
3. SEX Female		4. RACE White		5. DATE OF BIRTH Oct. 24, 1882		6. AGE (In years lost birthday) 86 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) Benevola, Md.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington Md.				
10. CITY OR TOWN OF DEATH Boonsboro			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Rfd. 2			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Washington		13c. CITY OR TOWN Boonsboro		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 44 N. Main St.	
14. FATHER'S NAME First Daniel Middle Webster Last Foltz			15. MOTHER'S MAIDEN NAME First Lydia Middle Ann C. Last Toms							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No.			16b. SOCIAL SECURITY NO. 216-54-8588		17. INFORMANT Address Mr. Leonard D. Emmert, Rfd. 2, Boonsboro, Md					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) A few carcinoma of right breast 174X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5-5-1966	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c) Arterio-sclerotic heart & June										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 5-18 , 19 69 , to June 22 , 19 69 , that (I) (we) last saw the deceased alive on June 22 , 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE John H. Bast, Jr.		DEGREE JOSEPH SECONDARY		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 6-23-1969				
22d. PHYSICIAN'S NAME (Type) JOSEPH SECONDARY		22e. ADDRESS Boonsboro Md								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6-25-69		23c. NAME OF CEMETERY OR CREMATORY Boonsboro Cemetery		23d. LOCATION (City or Town) (County) (State) Boonsboro, Wash. Co., Md.				
24. FUNERAL DIRECTOR John H. Bast, Jr. 112 N. Main St. Boonsboro, Md				ADDRESS		25a. REC'D BY REGISTRAR JUN 27 1969		25b. REGISTRAR'S SIGNATURE		

28020

• N • E • U

• 20 •

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

09035

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09027

1. DECEASED-NAME (Type or print)			First	Middle	Lost	2a. DATE OF DEATH			2b. HOUR		
Edward Gerald French						June 27 1969			1230 A.M.		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Male		Negro		Nov 22 1928		40		MONTHS		DAYS	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH			12b. KIND OF BUSINESS OR INDUSTRY		
Hagerstown Md.		USA				Washington			Md.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
Hagerstown Md.		245 N. Jonathan St.		Janitor							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) - STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER			
Maryland		Washington		Hagerstown		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		245 N. Jonathan St.			
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
Nathaniel					French	Unknown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address		
Yes			World War 2			Miss Laurabell Seal			245 N. Jonathan		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION (H3) 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ATHEROSCLEROTIC CORONARY ARTERY DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SECONDS AT LEAST 2 YEARS.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 9 FEB, 1962, to 27 JUNE, 1969, that (I) (we) lost saw the deceased alive on 21 JUNE 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE			DEGREE			ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
W. N. FENDER										27 JUNE 1969	
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS								
W. N. FENDER			218 N. POTOMAC ST. HAGERSTOWN, MD								
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Burial		6-30-1969		Rose Hill Cemetery		Hagerstown		Wash.		Md.	
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
John R. Waters Jr			Hagerstown Md			JUN 30 1969		Charles Judge			

00035

RECEIVED 11 APR 1954

0200



180X

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

09036				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				09028							
1. DECEASED-NAME (Type or print)				First		Middle		Last		2a. DATE OF DEATH Month Day Year			2b. HOUR M		
Charlotte Elizabeth Frisby										June 4 1969					
3. SEX		4. RACE		5. DATE OF BIRTH				6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN			
Female		Negro		Nov 8 1919				49 YRS.							
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington Md.									
Hagerstown Md		USA													
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY			
Hagerstown Md				Washington County Hosp				Housewife				Own home			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER					
Maryland				Washington		Hagerstown				601 N. Prospect St.					
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last											
Richard Lyles				Christine French											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or (unknown)				16b. SOCIAL SECURITY NO.		17. INFORMANT Address									
no				214-34-0276		Douglas Frisby 601 N. Prospect St									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Obstruction of small intestine</u> <u>180X</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Anaplastic Carcinoma of cervix with</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>peric and intraperitoneal metastases</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>14 days</u> <u>6 months</u>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
5/29/69		intestinal obstruction													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that (I) (this hospital) attended the deceased from <u>May 26</u> , 19 <u>69</u> , to <u>June 4</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>June 4</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <u>Omar D. Sprecher, Jr. M.D.</u> DEGREE						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>6/4/69</u>							
22d. PHYSICIAN'S NAME (Type) <u>Omar D. SPRECHER, Jr.</u>						22e. ADDRESS <u>Hagerstown, Md.</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)							
Burial		6-9-1969		Rose Hill Cemetery				Hagerstown Wash Md							
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE							
<u>John R Watson Jr Hagerstown Md</u>						JUN 6 1969		<u>Charles Judge</u>							

2/2/42
 Character of Social Welfare
 The purpose of the survey was
 to determine the extent of
 social and industrial relations

2/2/42
 Social and industrial relations

2/2/42
 Social and industrial relations

2/2/42
 Social and industrial relations

4379

2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
09037					09029					
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH			2b. HOUR		
First Middle Last					Month Day Year			A M		
THEO HILBERT FUSS Sr					June 22 1969			5		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN		
Male		White		Aug 13 1882		86 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.		
W. Va.		USA				Washington				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY				
Hagerstown R # 6		Reid		Farmer		Retired				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER		
Maryland		Washington		Hagerstown				Marsh Pike		
14. FATHER'S NAME First Middle Last					15. MOTHER'S MAIDEN NAME First Middle Last					
John F. Fuss					Eliza J. Beard					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO		17. INFORMANT		Address		R # 6		
No		A 212-14-7395		Mrs Catherine Grimm Hagerstown Md						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART 1. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) <u>Cerebral Arteriosclerosis</u>										
DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
(b) <u>Arteriosclerotic Vascular Disease, Severe</u>										
DUE TO, OR AS A CONSEQUENCE OF										
(c) <u>Senility</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>1-2-</u> , 19 <u>69</u> , to <u>6-22-</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>6-20-</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (not) view the body after death.										
22b. SIGNATURE <u>E. W. Ditto, Jr.</u>					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>6-23-69</u>			
22d. PHYSICIAN'S NAME (Type) <u>Dr. E. W. Ditto, Jr.</u>					22e. ADDRESS <u>215 W. Washington St., Hagerstown, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		6/24/69		Dunkard Cemetery		Broadfording Wash Co Md				
24. FUNERAL DIRECTOR <u>Hagerstown Md</u>					ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
A ndrew K. Coffman Funeral H ome Inc					DATE <u>JUN 25 1969</u>		<u>Charles Judge</u>			

08032

08032

TO: DIRECTOR, FBI (100-371000) FROM: SAC, NEW YORK (100-100000) (P)

RE: JAMES EARL RAY, AKA; ALIEN; C. I. NO. 100-100000

NY 100-100000 (P) X

NY 100-100000 (P) X

NY 100-100000 (P) X

NY 100-100000 (P) X

NY 100-100000 (P) X

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NY 100-100000 (P) X

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																							
<div>09038</div> <div>CERTIFICATE OF DEATH</div> <div>09030</div>																							
1. DECEASED-NAME (Type or print)			First IDA			Middle M.			Last GARDNER			2a. DATE OF DEATH Month June			Day 13			Year 1969			2b. HOUR 11:50 A. M.		
3. SEX Female			4. RACE White			5. DATE OF BIRTH Oct. 20th. 1882			6. AGE (In years last birthday) 86			IF UNDER 1 YEAR MONTHS			IF UNDER 24 HRS. HOURS			MIN.					
7a. BIRTHPLACE (State or foreign country) Pa.			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Washington Co. Md.														
10. CITY OR TOWN OF DEATH Maugansville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Mennonite Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Home			12b. KIND OF BUSINESS OR INDUSTRY Home														
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Pa.			13b. COUNTY Franklin			13c. CITY OR TOWN Chambersburg			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 246 W. King St.											
14. FATHER'S NAME First David C. Myers			Middle Last			15. MOTHER'S MAIDEN NAME First Mary			Middle Lehman			Last											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16b. SOCIAL SECURITY NO. 191-26-6495 A			17. INFORMANT 1825 Edgar Ave. Mrs. Clarence Witmer, Chambersburg Pa.																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Arteriosclerotic Vascular Disease, Severe</u> DUE TO, OR AS A CONSEQUENCE OF <u>Cellulitis Involving Entire Right</u> <u>Side Of Face And Neck.</u>																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 years 10 years 5 days					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)																	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State																	
22a. I certify that (I) (we) attended the deceased from Jan. 19 68, to June 13, 19 69, that (I) (we) last saw the deceased alive on June 11, 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																							
22b. SIGNATURE <i>E. W. Ditto Jr.</i>			DEGREE			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 6/14/69														
22d. PHYSICIAN'S NAME (Type) E. W. DITTO, JR.			22e. ADDRESS 215 W WASHINGTON ST., HAGERSTOWN, MD.																				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 6/16/1969			23c. NAME OF CEMETERY OR CREMATORY Mennonite Cemetery			23d. LOCATION (City or Town) (County) (State) Chambersburg-Greene-Franklin Co. Penna.														
24. FUNERAL DIRECTOR <i>Charles M. Rayer</i>			ADDRESS HAGERSTOWN, MD.			25a. REC'D BY REGISTRAR DATE JUN 18 1969			25b. REGISTRAR'S SIGNATURE <i>Alvin A. Judge</i>														

25.000

4109

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

09039

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09031

1. DECEASED-NAME (Type or print) Olive Delancey Gardner			2a. DATE OF DEATH 6 Month 5 Day 69 Year			2b. HOUR M			
3. SEX female		4. RACE white		5. DATE OF BIRTH Feb, 3, 1872		6. AGE (In years last birthday) 97 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington			
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 915 W. Washington St.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Wash.		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 915 W. Washington St.	
14. FATHER'S NAME First John Middle Wiles Last Wiles			15. MOTHER'S MAIDEN NAME First Martha Middle Moser Last Moser						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes (a, or unknown)		16b. SOCIAL SECURITY NO. 216-54-8270		17. INFORMANT J1 Austin Gardner		Address Hagerstown, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute myocardial infarction 4100 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) old stroke								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs many years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Essential Hypertension; Cholesterol arteriosclerosis & old stroke									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from May 19, 63 , to June 5, 19 69 , that (I) (we) last saw the deceased alive on May 19, 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Edward S. Hardy				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 6/5/69			
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE 6-9-69		23c. NAME OF CEMETERY OR CREMATORY Smithsburg Cemetery		23d. LOCATION (City or Town) (County) (State) Smithsburg, Md.			
24. FUNERAL DIRECTOR Minnich Funeral Home				ADDRESS Hagerstown, Md.		25a. REC'D BY REGISTRAR JUN 9 1969		25b. REGISTRAR'S SIGNATURE W. Charles Judge	

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STATE OF OHIO

John W. ...

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
09040 CERTIFICATE OF DEATH 09032									
1. DECEASED-NAME (Type or print)			First	Middle	Lost	2a. DATE OF DEATH Month Day Year			2b. HOUR
CURTIS ANDREW GOLLER						JUNE 30 1969			8P. M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. UNDER 1 YEAR MONTHS DAYS	
MALE		WHITE		11/2/1916		52 YRS.		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
West Virginia		U.S.A.				WASHINGTON Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
HAGERSTOWN			WASH. CO. HOSPITAL			SECY. TREAS. TOOL SUPPLY CO.			
13a. USUAL RESIDENCE (Where deceased admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER
MARYLAND			WASHINGTON			HAGERSTOWN		1010 HAMILTON BLVD.	
14. FATHER'S NAME First Middle Lost			15. MOTHER'S MAIDEN NAME First Middle Lost						
GEORGE A. GOLLER			LAURA M. MICHAEL						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT			
NO			232-28-2867			MRS. RUTH S. GOLLER MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Septicemia</u>									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									
(b) <u>Septicemia of Directing Admission of State</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(c) <u>Septicemia of Directing Admission of State</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
<u>Septicemia of Directing Admission of State</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, EARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.		City or Town		County State
22a. I certify that (I) (this hospital) attended the deceased from <u>June 30, 1969</u> to <u>June 30, 1969</u> , that (I) (we) lost saw the deceased alive on <u>June 30, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		EDSON B. MOODY M.D.			22c. DATE SIGNED		8/2/69		
22d. PHYSICIAN'S NAME (Type)		EDSON B. MOODY M.D.			22e. ADDRESS		363 S. CLEVELAND AVE. HAGERSTOWN MD		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)	
BURIAL		7/3/69		REST HAVEN CEM.		HAGERSTOWN WASH. MD,			
24. FUNERAL DIRECTOR		ADDRESS			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
W. J. Harment, Hagerstown, Md					JUL 1 1969		Charles Judge		

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DEATH AND BURIAL RECORDS

JUNE 30 1902

COPIES

ANDREW

11/11/11

WHITE

MALE

WASHINGTON

D.C.

AGE 35

JOHN J. BROWN

WASHINGTON

D.C.

AGE 40

JOHN J. BROWN

WASHINGTON

D.C.

AGE 40

JOHN J. BROWN

WASHINGTON

D.C.

AGE 40

11-11-11

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JOHN J. BROWN

WASHINGTON

D.C.

AGE 40

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
Rankin T. Gossert						Month Day Year June 23 1969			M
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS
Male		White		Dec. 19, 1921			47 YRS.		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			Md.
Penna.		U.S.A.				Washington			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Hagerstown			Washington County Hosp.			Guard		Grove Mfg. Co.	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)			13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		
Penna.			Franklin		Waynesboro YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Waynesboro R. D. 4		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
James A. Gossert			Ida M. Monn						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT				
yes			WW II		Mrs. Rankin T. Gossert				
			205-09-9527		Waynesboro #4, Pa.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Meningitis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Brain abscess</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Abscess abdominal cavity</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day ? months. ? months.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Yes.		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>6-21-69</u> , 19 <u> </u> , to <u>6-23-69</u> , 19 <u> </u> , that (I) (we) last saw the deceased alive on <u>6-22-69</u> , 19 <u> </u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>A. F. Abdullah</u>					DEGREE ATTENDING PHYS.		MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED June 30, 1969
22d. PHYSICIAN'S NAME (Type) A. F. Abdullah, M. D.					22e. ADDRESS 318 N. Potomac St. Hagerstown, Md. 21740				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial		6/25/1969		Quincy Cemetery			Quincy Twp., Franklin, Pa.		
24. FUNERAL DIRECTOR <u>Harold G. Gax</u>					25a. REC'D BY REGISTRAR Waynesboro, Penna.		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE JUL 3 1969

00001

00001

June 23 1951

Goose

Franklin

Male

White

Dec. 20, 1951

Washington

U.S.A.

Female

In front of

Washington County House

Female

Franklin

Washington

X

Washington D.C.

June 23

Goose

Ida

June 23

June 23

Goose

Franklin

June 23

June 23/1951

Goose

Franklin

Washington, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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<div style="display: flex; justify-content: space-between;"> 09042 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 09034 </div> <div style="text-align: center;"> CERTIFICATE OF DEATH </div>											
1. DECEASED-NAME (Type or print) John William Hill						2a. DATE OF DEATH Month June Day 5 Year 1969			12b. HOUR 11:50 AM		
3. SEX Male		4. RACE Negro		5. DATE OF BIRTH Aug 10 1875		6. AGE (In years last birthday) 88 93 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS. HOURS 0 MIN 0	
7a. BIRTHPLACE (State or foreign country) Taneytown Md		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington Md.					
10. CITY OR TOWN OF DEATH Hagerstown Md		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington County Hosp				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 131 W. Bethel Street			
14. FATHER'S NAME First Unknown Middle Last 				15. MOTHER'S MAIDEN NAME First Unknown Middle Last 							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no		16b. SOCIAL SECURITY NO. 214-54-0083		17. INFORMANT Washington County Welfare Board				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease with congestive failure 4123 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Indefinite											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from Feb. 3 , 19 69 , to June 5 , 19 69 , that (I) (we) last saw the deceased alive on June 5 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE B. B. Kneisley M.D.				DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 6/9/69			
22d. PHYSICIAN'S NAME (Type) B. B. Kneisley, M.D.				22e. ADDRESS 148 West Washington Street Hagerstown, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6-11-1969		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Hagerstown Wash. Md.					
24. FUNERAL DIRECTOR John R Watson Jr. Hagerstown, Md.				ADDRESS		25a. REC'D BY REGISTRAR JUN 13 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

MEDICAL CERTIFICATION

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18&22a Film 414 MEDICAL EXAMINER'S CERTIFICATE OF DEATH
7-14-69 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09043

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09035

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			Month Day Year			2b. HOUR			
WALTER EDGAR HOFFMAN						June 2, 1969			P. M.						
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		2d. HOUR	
Male		White		Nov 4 1904		64 YRS		MONTHS DAYS		HOURS MIN.		June 3, 1969		7:45 P. M.	
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED			NEVER MARRIED			9. COUNTY OF DEATH			
Maryland			U.S.A.			WIDOWED			DIVORCED			Washington Md.			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY			
Hagerstown				608 No Prospect St				Silk Weaver							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?			
Maryland				Washington				Hagerstown				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME				First Middle Last				15. MOTHER'S MAIDEN NAME				First Middle Last			
Frank Hoffman								Myrtle Rudisill							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS			
No				174-05-0036				Mrs Betty L. Diffendall R #2				Smithsburg, Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY:												36 hours			
IMMEDIATE CAUSE (a) <u>Pending</u> Pulmonary embolism, terminal															
DUE TO, OR AS A CONSEQUENCE OF Lobular pneumonia, right lung & portions of left upper lobe (probably aspiration)															
(b) <u>Aspiration of gastric contents into larynx, trachea and bronchial tree</u>															
(c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)															
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?			
												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)							
				HOUR A.M. P.M. 19											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE				M.D.				22b. DATE SIGNED							
<u>Dr. E. W. Ditto, Jr.</u>								June 4, 1969							
EXAMINER'S NAME (Type)				215 W. Washington St., Hagerstown, Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)			
Burial				6/6/69				Smithsburg Cemetery				Smithsburg Wash Co Md			
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
Andrew K. Coffman Funeral Home Inc								JUN 9 1969				<u>John A. Judge</u>			

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WILSON & COMPANY, 112 N. 1st St. N. W.

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WILSON & COMPANY, 112 N. 1st St. N. W.

WILSON & COMPANY, 112 N. 1st St. N. W.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR	
Milford Joseph				Howell	6	24	69	6:35 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Male		White		5/7/02		67 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
W. Va		U.S.A.				Washington Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Hagerstown		Wash. Co. Hospital		Farmer		Retired			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Md.		Wash.		Hag. #1				Dual Highway	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
First Middle Last		First Middle Last							
James F. Howell		Ann Mahoney							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
No		220-28-3273		Mrs Jessie M. Howell		Dual Highway			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>Septicemia</u> <u>1538</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cellulitis of abdominal wall with gangrene</u> <u>9 days</u> (c) <u>Intestinal obstruction, wound dehiscence</u> <u>23 days</u> (d) <u>Metastatic adenocarcinoma of colon</u> <u>2 months</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Diabetes Mellitus</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
6/7/69		Intestinal obstruction							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>June 1</u> , 19 <u>69</u> , to <u>June 24</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>June 24</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED			
Omar D. Sprueher, Jr. M.D.						6/25/69.			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
OHAR D. SPRECHER		1229 Ravenwood Hqts, Hagerstown, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		6/27/69		Fairview Cemetery		Keedysville Wash. Co. Md.			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Hagerstown Md				JUN 30 1969		Charles Judge			
Andrew K. Coffman Funeral Home Inc									

1538

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1538

Items 4, 7, & 23 Film 4114 7/11/69 kk										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										09045		09037		
1. DECEASED-NAME (Type or print) First <u>WILSON</u> Middle <u>Y.</u> Last <u>JEFFERSON</u>										2a. DATE OF DEATH Month <u>JUNE</u> Day <u>28</u> Year <u>1969</u>										2b. HOUR <u>10:54</u> M				
3. SEX <u>M</u>			4. RACE <u>Negro</u>			5. DATE OF BIRTH <u>JULY 27, 1905</u>			6. AGE (In years last birthday) <u>63</u> YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN										
7a. BIRTHPLACE (State or foreign country) <u>Va. USA</u>			7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. COUNTY OF DEATH <u>WASHINGTON COUNTY</u> Md.															
10. CITY OR TOWN OF DEATH <u>Hagerstown, Md.</u>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Western Md. State Hospital</u>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Janitor</u>			12b. KIND OF BUSINESS OR INDUSTRY															
13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE <u>Md.</u>			13b. COUNTY <u>MONT.</u>			13c. CITY OR TOWN <u>Takoma Park</u>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <u>666 Houston Street</u>													
14. FATHER'S NAME First <u>Martin</u> Middle <u>Jefferson</u> Last <u>Christian</u>			15. MOTHER'S MAIDEN NAME First <u>Pauline</u> Middle <u>Christian</u> Last <u>Christian</u>																					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <u>Yes</u> <u>WW-II</u>			16b. SOCIAL SECURITY NO. <u>WW-II</u>			17. INFORMANT Address <u>David B. Guion, 807 Tuckerman St., N.W.-D.C.</u>																		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <u>1538</u> IMMEDIATE CAUSE (a) <u>CARCINOMA COLON</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																								
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)														
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State														
22a. I certify that (he) (this hospital) attended the deceased from <u>10-15</u> , 19 <u>68</u> , to <u>6-28</u> , 19 <u>69</u> , that (I) (he) last saw the deceased alive on <u>6-28</u> , 19 <u>69</u> , and that in (my) (his) opinion death occurred on the date and hour and from the causes stated above, (I) (he) (did) (did not) view the body after death.																								
22b. SIGNATURE <u>Domingo A. Garcia</u>										DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>					22c. DATE SIGNED <u>JUNE 28, 1969</u>									
22d. PHYSICIAN'S NAME (Type) <u>DOMINGO A. GARCIA</u>										22e. ADDRESS <u>WESTERN MARYLAND STATE HOSPITAL</u>														
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					23b. DATE <u>7/2/69</u>					23c. NAME OF CEMETERY OR CREMATORY <u>Harmony Memorial Park</u>					23d. LOCATION (City or Town) (County) (State) <u>Landover, Md.</u>									
24. FUNERAL DIRECTOR <u>JOHN T. RHINES CO.</u>										ADDRESS <u>3015 12th Street, N.E.</u>					25a. RECEIVED BY REGISTRAR <u>JUL 7 1969</u>					25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				

Page 10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
09046									
CERTIFICATE OF DEATH									
09038									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR
HAZEL			MAY JONES			6 29 69			8:45 PM
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS
Female		White		April 18, 1920			49 YRS.		IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
Pa.		USA					Washington Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Hagerstown			Wash. Co. Hospital			Housewife			Own Home
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Md.			Washington		Hag.		YES		1107 Kuhn Ave.
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
William Rench Elliott			Harriett Mills						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or (unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT		Address		
No			217-28-5047		Franklin V. Jones		1107 Kuhn Ave.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Murder</u> <u>4122</u> DUE TO, OR AS A CONSEQUENCE OF <u>acute renal failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>nephrosclerosis</u> (c) <u>not known</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>3 days</u> <u>not known</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Art. Cardiovascular Disease & Diabetes Mellitus</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>March 1969</u> to <u>6/29</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>6/29</u> , 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Arturo Riego</u>		DEGREE ARTURO RIEGO		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>6/30/69</u>			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
ARTURO RIEGO		114 E. Antetam, Hagerstown							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		7/2/69		Church of the Brethren		Broadfording Wash. Md.			
24. FUNERAL DIRECTOR		Hagerstown, Md.		ADDRESS		25a. FILED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
A.K. Coffman Funeral Home Inc.						JUL 2 1969		<u>[Signature]</u>	
						DATE			

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7. 以上各款均須於中華民國二十一年一月一日以前完成。

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

4109

1

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
09047 CERTIFICATE OF DEATH 09039										
1. DECEASED-NAME (Type or print) First Middle Last Minnie Maude Keifer					2a. DATE OF DEATH 6 Month 14 Day 69 Year			2b. HOUR 6:10		
3. SEX female		4. RACE white		5. DATE OF BIRTH Aug. 31, 1884		6. AGE (In years last birthday) 84 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington Md.				
10. CITY OR TOWN OF DEATH Hagerstown			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Martin Manor Nursing Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) housewife		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY Wash.		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 717 Virginia Ave.	
14. FATHER'S NAME First Middle Last George W. Noel					15. MOTHER'S MAIDEN NAME First Middle Last Mary Justice					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) no			16b. SOCIAL SECURITY NO.		17. INFORMANT Address John Hartle, Hagerstown, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>4109</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>30 min</u> <u>many</u> <u>years</u>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Hypertension, Arteriosclerosis</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>July 1961</u> to <u>June 6, 1969</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>April 12, 1969</u> and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>(we)</u> <u>(did)</u> <u>(did not)</u> view the body after death.										
22b. SIGNATURE <u>Edson B. Moody</u>					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>6/14/69</u>			
22d. PHYSICIAN'S NAME (Type) Edson B. Moody, M.D.					22e. ADDRESS 363 S. Cleveland Ave. Hagerstown, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE 6-17-69		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City or Town) (County) (State) Hagerstown Md.				
24. FUNERAL DIRECTOR ADDRESS Minnich Funeral Home Hagerstown, Md.					25a. REC'D BY REGISTRAR JUN 18 1969		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

00007

STATE OF DEATH

Name: [illegible] Address: [illegible] City: [illegible] State: [illegible] Date: [illegible]

Age: [illegible] Sex: [illegible] Race: [illegible] Religion: [illegible]

Marital Status: [illegible] Education: [illegible] Occupation: [illegible]

Place of Birth: [illegible] Date of Birth: [illegible]

Signature of Deceased: [illegible]

Signature of Witness: [illegible]

Signature of Physician: [illegible]

Signature of Coroner: [illegible]

Signature of Burial Place: [illegible]

Signature of Burial Place: [illegible]

Signature of Burial Place: [illegible]

Signature of Burial Place: [illegible]

Signature of Burial Place: [illegible]

Signature of Burial Place: [illegible]

Signature of Burial Place: [illegible]

Signature of Burial Place: [illegible]

Signature of Burial Place: [illegible]

Signature of Burial Place: [illegible]

Signature of Burial Place: [illegible]

09048

09040

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Preston Miller Kendle			2a. DATE OF DEATH June Month 23 Day 1969 Year			2b. HOUR 7:10 A M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH 3/16/96		6. AGE (In years last birthday) 73 YRS.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH WASHINGTON COUNTY Md.	
10. CITY OR TOWN OF DEATH HAGERSTOWN		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WESTERN MD. STATE HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Night watchman		12b. KIND OF BUSINESS OR INDUSTRY Ribbon Co.	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 43 E. Baltimore Street							
14. FATHER'S NAME First Middle Last Samuel Milford Kendle			15. MOTHER'S MAIDEN NAME First Middle Last Mary Louise Carty				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 220-16-2420-A		17. INFORMANT Address Mrs. P.M. Kendle 43 E. Baltimore, St. Hagerstown, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Inanition 1562 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of Ampulla of Vater DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks 2 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (the hospital) attended the deceased from June 3, 1969 to June 23, 1969 , that (I) (we) lost saw the deceased alive on June 23, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Edwin G. Riley, M.D.		22c. DATE SIGNED 6/23/69		22d. ADDRESS Western Maryland State Hospital, 1500 Pennsylvania Ave., Hagerstown, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6/25/69		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City or Town) (County) (State) Hagerstown-Washington-Md.	
24. FUNERAL DIRECTOR Rest Haven Funeral Chapel Hagerstown, Md.		25a. REC'D BY REGISTRAR JUN 25 1969		25b. REGISTRAR'S SIGNATURE Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DEPARTMENT OF HEALTH

Proctor, Ellen, Female, June 27, 1901, 1113

White, 2/20/00, 12

Washington County, 12

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Handwritten signature: William B. Berry

800, G. H. Jones, M.D.

12/27/04

12/27/04

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

09049										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										09041														
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR														
First Middle Last										Month Day Year										3 P M														
EFFIE MYRTLE LAPOLE										June 6 1969										3 P M														
3. SEX					4. RACE					5. DATE OF BIRTH					6. AGE (In years last birthday)					IF UNDER 1 YEAR					IF UNDER 24 HRS.									
Female					White					July 20 1884					84 YRS.					MONTHS DAYS HOURS MIN.														
7a. BIRTHPLACE (State or foreign country)					7b. CITIZEN OF WHAT COUNTRY?					8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH																			
Maryland					Washington										Washington Md.																			
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)					12b. KIND OF BUSINESS OR INDUSTRY																			
Hagerstown					737 Washington Ave					Housewife					Own Home																			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE					13b. COUNTY					13c. CITY OR TOWN					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e. STREET AND NUMBER														
Maryland					Washington					Hagerstown					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					737 Washington Ave														
14. FATHER'S NAME First Middle Last										15. MOTHER'S MAIDEN NAME First Middle Last																								
Nathan D. Monninger										Martha Eliz. Shank																								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or (unknown) No					16b. SOCIAL SECURITY NO. (If yes give war or dates of service) --					17. INFORMANT Address																								
					218-24-2002					Mrs Betty Tarsus 737 Washington Ave																								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)															Hagerstown Md.																			
PART 1. DEATH WAS CAUSED BY:															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
IMMEDIATE CAUSE (a) 4123 ARTERIOSCLEROTIC HEART DISEASE															Yrs.																			
DUE TO, OR AS A CONSEQUENCE OF																																		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause															Yrs.																			
(b) ARTERIOSCLEROSIS, GENERALIZED																																		
DUE TO, OR AS A CONSEQUENCE OF																																		
(c)																																		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																																		
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State																								
22a. I certify that (I) (this hospital) attended the deceased from 14 Sept, 1965, to 6 June, 1969, that (I) (we) lost the deceased alive on February 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																		
22b. SIGNATURE															22c. DATE SIGNED																			
J. N. FENDER M.D. DEGREE															7 June '69																			
22d. PHYSICIAN'S NAME (Type)															22e. ADDRESS																			
J. N. FENDER															218 N. Peronne St. Hagerstown Md																			
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION (City or Town) (County) (State)																			
Burial					6/9/69					Rose Hill Cemetery					Hagerstown Wash Co Md																			
24. FUNERAL DIRECTOR															25a. REC'D BY REGISTRAR										25b. REGISTRAR'S SIGNATURE									
Hagerstown Md. ADDRESS															JUN 11 1969										Charles Judge									
Andrew K. Coffman Funeral Home Inc																																		

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UNITED STATES OF AMERICA

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**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 1 Filed <u>7/2/69</u> llw <u>09050</u> MEDICAL EXAMINER'S CERTIFICATE OF DEATH										09042		
1. DECEASED NAME <u>A/K/A First June H. Leach Middle</u> (Type or Print) ELSIE JUNE LEACH						2a. DATE KNOWN <input checked="" type="checkbox"/> Month Day Year OF ESTI- <u>6-9-</u> <u>1969</u> DEATH MATED <input type="checkbox"/> <u>4</u> <u>PM</u>		2b. HOUR		2d. HOUR		
3. SEX <u>female</u>		4. RACE <u>white</u>		5. DATE OF BIRTH <u>6-9-01</u>		6. AGE (In years last birthday) <u>68</u> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) <u>Michigan</u>			7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Washington</u>			Md	
10. CITY OR TOWN OF DEATH <u>Hagerstown</u>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>RFD 2</u>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>social worker</u>			12b. KIND OF BUSINESS OR INDUSTRY <u>gov.</u>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Va.</u>						13b. COUNTY <u>Alexandria</u>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <u>Mt. Vernon Ave.</u>		
14. FATHER'S NAME First Middle Last <u>Gilbert L. Hicks</u>						15. MOTHER'S MAIDEN NAME First Middle Last <u>Nancy Kip</u>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO. <u>378-18-2383</u>		17. INFORMANT ADDRESS <u>Bruce Campbell, Richmond, Va.</u>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fractured neck, C3-4</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>8159</u> (b) <u>and crushing injury to chest +</u> DUE TO, OR AS A CONSEQUENCE OF <u>trauma</u> (c) <u>Multiple Fractures.</u>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. <u>4:45</u> P.M. <u>6-9-1969</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <u>Auto Accident - Struck guard rail</u>						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <u>I 70 - Highway</u>		21f. LOCATION Street or R.F.D. No. <u>I 70 west, Hagerstown</u>		City or Town <u>Wash</u>		County <u>MD</u>		State <u>MD</u>		
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <u>Edward W. Ditto, III</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED <u>6-11-69</u>				
EXAMINER'S NAME (Type) <u>EDWARD W. DITTO, III, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
				ADDRESS (Street, city, town, or county) <u>217 W. WASHINGTON ST. HAGERSTOWN, MARYLAND</u>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>6-13-69</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Evergreen cemetery</u>				23d. LOCATION (City or Town) (County) (State) <u>Lansing, Mich.</u>				
24. FUNERAL DIRECTOR ADDRESS <u>Minnich Funeral Home, Hagerstown, Md.</u>						25a. REC'D BY REGISTRAR <u>JUN 12 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
William Hudson Lillard						Month Day Year June 29 1969			M
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS
Male		White		July 11, 1892			76 YRS.		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			Md.
Turray, Va.		USA				Washington			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Rural-Hagerstown			Hagdon Manor Conv. Home			Salesman			Bakery
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Maryland			Washington		Hagerstown		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		9 Snyder Ave.
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Charles William Lillard			Emma Gochenour						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
No			214-09-6258A		Robert L. Lillard 34 Mountain Rd. Thurmont, Md. 21788				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u>									2 day
4124 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral arteriosclerosis</u>									yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerosis of the Cor. Ar.</u>									years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
<u>Ht. previous stroke & left hemiplegia. Cystitis, Chr.</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Richard T. Binford</u>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 30 June 69		
22d. PHYSICIAN'S NAME (Type) Richard T. Binford, M.D.					22e. ADDRESS 135 Potomac Ave, Hagerstown, Md. 21740				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial		7/2/69		Rest Haven Cemetery			Hagerstown-Washington-Md.		
24. FUNERAL DIRECTOR <u>Wm. C. Frost</u>					25a. REC'D BY REGISTRAR JUL 2 1969		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		
Rest Haven Funeral Chapel Hagerstown, Md.									

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1. *Journal of Management Studies*, 1990, 27, 1.

³மேலும், அமைதி உறுதியாகியது.

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1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 26

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• *Antennae* 11-segmented, 1st segment 1.5 times length of 2nd segment, 3rd segment 1.5 times length of 4th segment, 5th segment 1.5 times length of 6th segment, 7th segment 1.5 times length of 8th segment, 9th segment 1.5 times length of 10th segment, 11th segment 1.5 times length of 12th segment.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

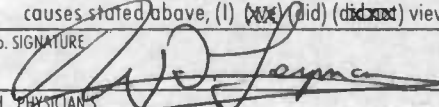
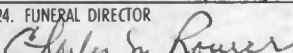

09052

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09044

Item 16 Film 413 6/20/69 kk

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR			
LESTER				NMI	LUSHBAUGH	JUNE 13 69			8:50 PM			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS			
MALE		WHITE		OCTOBER 24, 1893			75 YRS.		IF UNDER 24 HRS. HOURS MIN			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Md.					
MARYLAND		U.S.A.					WASHINGTON					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			
HAGERSTOWN			WASHINGTON COUNTY HOSP.			RETIRED MACHINE OPERATOR			ORGAN WORKS			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
MARYLAND			WASHINGTON			HAGERSTOWN				299 SUMMIT AVENUE		
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last	
JOHN				HENRY	LUSHBAUGH	KATIE			SHALL		RIDENOUR	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (not if unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address			
NO Yes			214-09-2741A			LEONARD A LUSHBAUGH			HAGERSTOWN, MARYLAND			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Respiratory Failure</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 month		
491X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) <u>Far advanced pulmonary emphysema</u>										11-12 years		
DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Chronic</u> <u>Bronchitis; Bronchial Asthma; Pneumonitis.</u>												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (the hospital) attended the deceased from <u>May 12</u> , 19 <u>69</u> , to <u>Jun 13</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>Jun 12</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) view the body after death.												
22b. SIGNATURE 						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 6/13/69			
22d. PHYSICIAN'S NAME (Type) WILLIAM T LAYMAN						22e. ADDRESS 301 E ANTIETAN ST., HAGERSTOWN, MD.						
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
BURIAL			6/15/69		REST HAVEN CEMETERY			HAGERSTOWN, WASHINGTON, MD.				
24. FUNERAL DIRECTOR 						ADDRESS HAGERSTOWN, MARYLAND			25a. REC'D BY REGISTRAR DATE JUN 17 1969		25b. REGISTRAR'S SIGNATURE 	

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09053

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09045

1. DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR							
Eva		Corrine	Martin	June 22 1969		11:11 AM								
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS							
Female	White		July 28, 1902		66 YRS.		IF UNDER 24 HRS HOURS MIN							
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.							
Washington Co., Md.	USA				Washington									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY								
Hagerstown		Washington County Hospital		Stitcher		Shoe Mfg.								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
Maryland		Washington		Mangansville		13e. STREET AND NUMBER								
						127 Greenfield Ave.								
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last					
William		Jacobs	Lucillia	Mongan										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address		Md.						
No		214-09-5342A		Mr. J. L. Martin		127 Greenfield Ave. Mangansville.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)														
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 4122 DUE TO, OR AS A CONSEQUENCE OF <u>Cardio-vascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Apoplexy</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Heart Disease</u>														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).														
19a. DATE OF OPERATION									19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)									21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work									21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 12-15-69, 19 to 6-22, 1969, that (I) (we) last saw the deceased alive on 6-22-69, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									22b. SIGNATURE <u>E. R. Laddig</u> M.D. DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. DATE SIGNED 6-27-69					
22d. PHYSICIAN'S NAME (Type) <u>E. R. Laddig</u>									22e. ADDRESS <u>801 South Howard St. Hagerstown, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)							
Burial			6/25/69		Rest Haven Cemetery		Hagerstown-Washington-Md.							
24. FUNERAL DIRECTOR <u>Wm. C. Host</u>					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Rest Haven Funeral Chapel Hagerstown, Md.					DATE JUN 27 1969		<u>Charles Judge</u>							

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July 28, 1902

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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4123

09054										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										09046																																																											
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																																																											
GRACE LEE MAYHEW										June 3 1969										M																																																											
3. SEX										4. RACE										5. DATE OF BIRTH										6. AGE (In years last birthday)										IF UNDER 1 YEAR										IF UNDER 24 HRS.																													
Female										White										July 27 1897										71 YRS.										MONTHS										DAYS										HOURS										MIN.									
7a. BIRTHPLACE (State or foreign country)										7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH										Md.																																							
Virginia										U.S.A.																				Washington																																																	
10. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)										12b. KIND OF BUSINESS OR INDUSTRY																																																	
Hagerstown										Wash County Hospital										Domestic										--																																																	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE										13b. COUNTY										13c. CITY OR TOWN										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e. STREET AND NUMBER																																							
Maryland										Washington										Hagerstown										YES										17 Public Square																																							
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME										Address																																																											
Dorsey A. Swink										Nellie E. Grant																																																																					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)										16b. SOCIAL SECURITY NO.										17. INFORMANT										Address																																																	
No										217-32-6725										Paul E. Mayhew										17 Public Square Hagerstown Md.																																																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																																																					
PART 1. DEATH WAS CAUSED BY:																																																																															
IMMEDIATE CAUSE (a) 4123 Cerebral Emboli										3 days																																																																					
DUE TO, OR AS A CONSEQUENCE OF																																																																															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										(b) Auricular Fibrillation										14 days +																																																											
										DUE TO, OR AS A CONSEQUENCE OF																																																																					
										(c) Arterio sclerotic Heart Disease										2 yrs. +																																																											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																																																																															
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes																																																	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																																																											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																																																											
22a. I certify that (I) (this hospital) attended the deceased from Nov. 1950, to June 3, 1969, that (I) (we) last saw the deceased alive on June 2, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																																																															
22b. SIGNATURE										DEGREE										ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c. DATE SIGNED																																																	
Lloyd A. Hoffman																														6/4/69																																																	
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS																																																																					
Lloyd A. Hoffman										214 N. Potomac St.																																																																					
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION (City or Town) (County) (State)																																																	
Burial										6/5/69										Rose Hill Cemetery										Hagerstown Wash Co Md																																																	
24. FUNERAL DIRECTOR										ADDRESS										25a. REC'D BY REGISTRAR										25b. REGISTRAR'S SIGNATURE																																																	
Hagerstown Md																				JUN 9 1969										Charles Judge																																																	
Andrew K. Coffman										Funeral Home Inc																																																																					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

09055

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09047

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)			First	Middle	Lost	2a. DATE OF DEATH			2b. HOUR		
Kitty				Louise	McBee	June Month 14 Day 1969 Year			M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female		White		Sept. 25, 1937		31 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Maryland		U.S.A.				Washington Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Hagerstown			Washington County			Housewife					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		
Maryland			Washington		Hagerstown		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1314 Jefferson Blvd.		
14. FATHER'S NAME			First	Middle	Lost	15. MOTHER'S MAIDEN NAME			First	Middle	Lost
Harry B. Wenschhof						Anna M. Koontz					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT						
No			177-30-7676		Address Jefferson, Blvd Richard V. McBee, Hagerstown, Md. 1341						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Brown Tumor</u> 2381 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from May 31, 1969, to June 14, 1969, that (I) (we) last saw the deceased alive on June 13, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Francisco E. Rosillo</u>						DEGREE ATTENDING PHYS.		<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.		22c. DATE SIGNED 6/17/69	
22d. PHYSICIAN'S NAME (Type) FRANCISCO E. ROSILLO						22e. ADDRESS 580 Northern Ave. Hg. Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial			June 17, 1969		Oak Lawn Memorial Gardens		Gettysburg, R.D.# 3 Pa.				
24. FUNERAL DIRECTOR Clarence E. Wilson						ADDRESS Emmitsburg, Md.		25a. REC'D BY REGISTRAR JUN 19 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

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RECEIPT OF CASH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in on the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
09056										
09048										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First Middle Lost			2a. DATE OF DEATH		2b. HOUR		
Sarah			Helen McBride			Month Day Year June 28, 1969		12:10 PM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		
Female		White		June 27, 1887		82 YRS.		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md		
Boonsboro, Md.		U. S. A.				Washington				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY				
Boonsboro		Fairney-Keedy Mem. Home		Housekeeper		Own Home				
13a. USUAL RESIDENCE (Where deceased admission) - STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13a. STREET AND NUMBER		
Maryland		Washington		Boonsboro				40 S. Main St.		
14. FATHER'S NAME			First Middle Lost			15. MOTHER'S MAIDEN NAME			First Middle Lost	
George W.			McBride			Frances			White	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		8910 Second St.		Address		
No.		218-52-5461		Mr. George W. McBride, Langam, Md.		20801				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of bladder</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertension & cardiac vascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yr 10 yrs		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 69		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State		
22a. I certify that (I) (this hospital) attended the deceased from <u>March 10, 1969</u> , to <u>June 28, 1969</u> , that (I) (we) last saw the deceased alive on <u>June 28, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		22f. REGISTERAR		
<u>G. W. He Van</u>		<u>June 30, 1969</u>		<u>M.D.</u>		<u>Boonsboro, Md</u>		<u>John H. Bast, Jr.</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		7- 1- 69		Boonsboro Mausoleum		Boonsboro, Wash. Co., Md.				
24. FUNERAL DIRECTOR				ADDRESS		25a. REG. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
John H. Bast, Jr. 112 N. Main St. Boonsboro, Md						JUL 1 1969		<u>John H. Bast, Jr.</u>		

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UNITED STATES

March 1900

June 27, 1897

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

09057										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										09049																													
MEDICAL EXAMINER'S CERTIFICATE OF DEATH																																																	
1. DECEASED-NAME (Type or Print) First Middle Last SARAH ADELAIDE McCARREN										2a. DATE KNOWN OF ESTI-DEATH MATED <input checked="" type="checkbox"/> Month Day Year JUNE 5, 1969										2b. HOUR 4:35 PM																													
3. SEX FEMALE			4. RACE WHITE			5. DATE OF BIRTH FEB. 28, 1882			6. AGE (In years last birthday) 87 YRS			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS HOURS MIN			2c. DATE PRONOUNCED DEAD Month 6 Day 5 Year 1969										2d. HOUR 4:35 PM																					
7a. BIRTHPLACE (State or foreign country) MARYLAND										7b. CITIZEN OF WHAT COUNTRY? U.S.A.										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH WASHINGTON Md.																			
10. CITY OR TOWN OF DEATH HAGERSTOWN										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WASHINGTON COUNTY HOSP.										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOMEMAKER										12b. KIND OF BUSINESS OR INDUSTRY OWN HOME																			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND										13b. CITY OR TOWN WASHINGTON										13c. CITY OR TOWN HAGERSTOWN										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e. STREET AND NUMBER 309 RADCLIFFE AVENUE									
14. FATHER'S NAME First Middle Last JAMES JACOB McGRATH										15. MOTHER'S MAIDEN NAME First Middle Last ANNA M NUSSEAR																																							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO										16b. SOCIAL SECURITY NO. 219-54-0513										17. INFORMANT ESTHER E McCARREN										309 ADDRESS RADCLIFFE AVE. HAGERSTOWN, MARYLAND																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism Secondary 887X										DUE TO, OR AS A CONSEQUENCE OF (b) to Subcapital fracture Rt femur.										DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 days																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Arteriosclerotic vascular Disease																																																	
19a. DATE OF OPERATION May 28, 1969										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Fracture Femur										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																													
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>										21b. TIME OF INJURY Month, Day, Year 9:40 P.M. May 26, 69										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) Fell at home in trailer																													
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>										21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home										21f. LOCATION Street or R.F.D. No. City or Town County State Fortney Court Hagerstown, Wash Md																													
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										ACTUAL SIGNATURE Edward W Ditto, III M.D.										CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>										22b. DATE SIGNED 6/6/69																			
EXAMINER'S NAME (Type) 217 W WASHINGTON ST., HAGERSTOWN, MD.										ADDRESS (Street, city, town, or county)																																							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL										23b. DATE 6/7/69										23c. NAME OF CEMETERY OR CREMATORY REST HAVEN CEMETERY										23d. LOCATION (City or Town) (County) (State) HAGERSTOWN, WASHINGTON, MD.																			
24. FUNERAL DIRECTOR Charles M. Rouze										ADDRESS HAGERSTOWN, MARYLAND										25a. REC'D BY REGISTRAR JUNE 11 1969										25b. REGISTRAR'S SIGNATURE Charles J. Judge																			

PROSTATE
HEALTH

10025

MEDICAL EXAMINATION CERTIFICATE OF DEATH

NAME OF DECEASED: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]

10025

1. Name of Deceased		2. Date of Death		3. Place of Death	
4. Sex		5. Age		6. Race	
7. Occupation		8. Cause of Death		9. Manner of Death	
10. Signature of Physician		11. Signature of Medical Examiner		12. Signature of Coroner	
13. Signature of Registrar		14. Signature of Clerk		15. Signature of Nurse	
16. Signature of Chaplain		17. Signature of Undertaker		18. Signature of Burial Society	
19. Signature of Cemetery		20. Signature of Funeral Home		21. Signature of Mortuary	
22. Signature of Embalmer		23. Signature of Crematorium		24. Signature of Interment	
25. Signature of Burial		26. Signature of Reinterment		27. Signature of Disposition	
28. Signature of Final Disposition		29. Signature of Final Disposition		30. Signature of Final Disposition	

09058

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09050

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Owen James Mesner			2a. DATE OF DEATH 6 Month 20 Day 69 Year			2b. HOUR M			
3. SEX male		4. RACE white		5. DATE OF BIRTH March 16, 1909		6. AGE (In years last birthday) 60 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) N. Y.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington Md.			
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Wash. Co. Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) teacher		12b. KIND OF BUSINESS OR INDUSTRY school			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Wash.		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 362 Daycotah Ave.	
14. FATHER'S NAME James H. Mesner			15. MOTHER'S MAIDEN NAME Lillie L. Newell						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no		16b. SOCIAL SECURITY NO. 234-38-9526		17. INFORMANT Address Mrs. Ruth Mesner Hagerstown, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 hours	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that W (this hospital) attended the deceased from June 19 19 69 , to June 20 , 19 69 , that (I) (we) last saw the deceased alive on June 20 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.									
22b. SIGNATURE Richard E. Smith, M.D. DEGREE					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 6/20/69		
22d. PHYSICIAN'S NAME (Type) Richard E. Smith, M.D.					22e. ADDRESS 998 Potomac Avenue, Hag., Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE 6-22-69		23c. NAME OF CEMETERY OR CREMATORY Greenway Cemetery		23d. LOCATION (City or Town) (County) (State) Berkeley Springs, W. Vir			
24. FUNERAL DIRECTOR ADDRESS Minnich Funeral Home Hagerstown, Md.					25a. RECEIVED BY REGISTRAR DATE JUN 24 1969		25b. REGISTRAR'S SIGNATURE Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1905

CERTIFICATE OF DEATH

00028



Given under my hand and seal of office this 10th day of March 1905

March 10, 1905

White

Washington

Residence of Deceased: 102 Lafayette Ave. Hagerstown, Md.

Lillie L. Howell

James H. Messer

Age: 23-1/2 years Date of Death: March 10, 1905

Cause of Death: ...

Signature of Physician: ...

Signature of Coroner: ...

Signature of Registrar: ...

Signature of ...

Signature of ...

Signature of ...

Signature of ...

Signature of ...

Signature of ...

Signature of ...

Signature of ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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09059

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

09051

1. DECEASED-NAME (Type or print) <i>Ida Kreps Miller</i>			2a. DATE OF DEATH Month <i>June</i> Day <i>28</i> Year <i>1969</i>			2b. HOUR <i>6:40</i> M			
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>September 2, 1889</i>		6. AGE (In years last birthday) <i>79</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <i>Clearspring, Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Washington</i> Md.			
10. CITY OR TOWN OF DEATH <i>Hagerstown</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Jackson Conwl. Home</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Washington</i>		13c. CITY OR TOWN <i>Hagerstown</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>632 N. Mulberry St.</i>	
14. FATHER'S NAME First <i>William</i> Middle <i>Yeakle</i> Last <i>Kate</i>			15. MOTHER'S MAIDEN NAME First <i>Kate</i> Middle <i>Forsyth</i> Last <i>Forsyth</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>No</i> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <i>214-09-7852</i>		17. INFORMANT Address <i>Mrs. G. Vincent Hull 11 E. 13th. St. Frederick, Md.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Arteriosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>4379</i> (b) <i>Arteriosclerotic Vascular Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>5 years</i>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Recent</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>6-17-</i> , 19 <i>68</i> , to <i>6-28-</i> , 19 <i>69</i> , that (I) (we) lost the deceased on <i>6-23-</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>A. E. W. Ditto, Jr.</i>		DEGREE <i>Dr. E. W. Ditto, Jr.</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>6-30-69</i>			
22d. PHYSICIAN'S NAME (Type) <i>Dr. E. W. Ditto, Jr.</i>		22e. ADDRESS <i>215 W. Washington St., Hagerstown, Md.</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>7/1/69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Rest Haven Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Hagerstown-Washington-Md.</i>			
24. FUNERAL DIRECTOR <i>Wm. C. Horst</i> <i>Rest Haven Funeral Chapel</i>				ADDRESS <i>Hagerstown, Md.</i>		25a. REC'D BY REGISTRAR DATE <i>JUL 2 1969</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

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STATE OF OHIO

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

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09060

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

09052

1. DECEASED-NAME (Type or print) First Middle Last Roy B. Misner			2a. DATE OF DEATH Month Day Year June 2, 1969			2b. HOUR M M						
3. SEX Male		4. RACE White		5. DATE OF BIRTH 3/13/1907		6. AGE (In years last birthday) 62 YRS.		IF UNDER 1 YEAR MONTHS DAYS 62		IF UNDER 24 HRS. HOURS MIN. 62		
7a. BIRTHPLACE (State or foreign country) Waynesboro #1, Pa.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington Md.						
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington Co., Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Barber		12b. KIND OF BUSINESS OR INDUSTRY Barber						
13a. USUAL RESIDENCE (Where deceased lived; if institution: Residence before admission) STATE Penna.		13b. COUNTY Franklin		13c. CITY OR TOWN Waynesboro		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 34 Philadelphia Ave.				
14. FATHER'S NAME First Middle Last Joseph C. Misner			15. MOTHER'S MAIDEN NAME First Middle Last Sarah A. Patterson									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO. 174-01-3853		17. INFORMANT Address Mrs. Mildred Misner, 34 Philadelphia Ave., Waynesboro Pa.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (b) Severe coronary atherosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) 4109 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 wks	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Embolic infarction of kidney, small bowel - abdominal												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Saddle embolus, aorta		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from 6/1 , 19 69 , to 6/3 , 19 69 , that (I) (we) last saw the deceased alive on 3/June 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Thomas V. Craig		22c. DATE SIGNED 6/6/69		22d. PHYSICIAN'S NAME (Type) Thomas V. Craig								
22e. ADDRESS 247 N. Potomac St., Hagerstown Md.												
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6/5/69		23c. NAME OF CEMETERY OR CREMATORY Prices		23d. LOCATION (City or Town) (County) (State) Waynesboro #2, Franklin Penna.						
24. FUNERAL DIRECTOR David Y. Grove		ADDRESS Waynesboro Pa.		25a. REC'D BY REGISTRAR DATE JUN 11 1969		25b. REGISTRAR'S SIGNATURE Charles Judge						

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Myocardial infarction
Severe coronary atherosclerosis

Cardiac = infarction of the heart, small vessel - all arteries
with evidence, etc. x

no

Thrombus
x
6/1/69

6/1/69

x

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

09061 Item 13 Film 413 6/20/69 kk		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		09053	
1. DECEASED-NAME (Type or print) First Middle Last JULIA MAY BELLE MOLLER			2a. DATE OF DEATH Month 12 Day 69 Year JUNE 12 69		2b. HOUR 11:10 AM
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH FEBRUARY 15, 1872		6. AGE (In years last birthday) 97 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) PENNSYLVANIA	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH WASHINGTON Md.	
10. CITY OR TOWN OF DEATH HAGERSTOWN	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) AVALON MANOR NURSING HOME		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND	13b. COUNTY WASHINGTON	13c. CITY OR TOWN HAGERSTOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER Hotel Alexander AVALON MANOR /	
14. FATHER'S NAME First Middle Last PETER GREEALUND		15. MOTHER'S MAIDEN NAME First Middle Last CALISTA SADLER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT 760 Address BRIARCLIFF DR MRS LOUISE WAGAMAN HAGERSTOWN, MARYLAND	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertensive cardiovascular disease,</u> DUE TO, OR AS A CONSEQUENCE OF <u>arteriosclerotic</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LOST. 4122 1 week 20 yr.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>XXXXX</u> , 19 <u>27</u> , to <u>June 12</u> , 19 <u>69</u> , that (I) (<u>xxx</u>) last saw the deceased alive on <u>June 12</u> , 19 <u>69</u> , and that in (my) (<u>xxx</u>) opinion death occurred on the date and hour and from the causes stated above, (I) (<u>xxx</u>) (<u>xxx</u>) (did not) view the body after death.					
22b. SIGNATURE <u>B. B. Kneisley</u>		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 6/13/69	
22d. PHYSICIAN'S NAME (Type) B. B. KNEISLEY		22e. ADDRESS 148 W WASHINGTON ST., HAGERSTOWN, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 6/14/69	23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY		23d. LOCATION (City or Town) (County) (State) HAGERSTOWN WASHINGTON, MD.
24. FUNERAL DIRECTOR <u>Charles M. Rausser</u>		ADDRESS HAGERSTOWN, MARYLAND		25a. REC'D BY REGISTRAR JUN 17 1969	25b. REGISTRAR'S SIGNATURE <u>Charles M. Rausser</u>

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DATE: JAN 12 1971

TO: DIRECTOR, FBI

FROM: SAC, NEW YORK

SUBJECT: [illegible]

RE: [illegible]

DATE: [illegible]

TO: [illegible]

FROM: [illegible]

SUBJECT: [illegible]

RE: [illegible]

DATE: [illegible]

TO: [illegible]

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SUBJECT: [illegible]

RE: [illegible]

DATE: [illegible]

TO: [illegible]

FROM: [illegible]

SUBJECT: [illegible]

09062

CERTIFICATE OF DEATH

09054

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN lb 2 Hrs. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RFD-1 Big Spring d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John Calvin Mongan		4. DATE OF DEATH Month June Day 15 Year 1969	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 18, 1917 52 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Driver		10b. KIND OF BUSINESS OR INDUSTRY Trucking	11. BIRTHPLACE (County & State, or foreign country) Wash. Md.
13. FATHER'S NAME John Calvin Mongan Sr.		14. MOTHER'S MAIDEN NAME Rose Smith	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 214-16-0868	
17. INFORMANT Mrs. Rose Mongan		Address RFD-1 Big Spring	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardia infarction DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) None			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 1 week	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 1 p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 6-15, 1969 to 6-15, 1969 that (I) (we) last saw the deceased alive on 6-15, 1969 and that death occurred at 2:40 PM , from causes and on the date stated above.			
22a. SIGNATURE ME Byrkit		22b. DATE SIGNED 6-16-69	
22c. PHYSICIAN'S NAME (Type) ME Byrkit		22d. ADDRESS Williamport Md	
23a. BURIAL, CREMATION, REMOVAL Specify Burial	23b. DATE THEREOF June 18, 69	23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	23d. LOCATION (City or Town) (County) (State) Hagerstown Wash. Md.
24. FUNERAL DIRECTOR Thompson Funeral Home		25. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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EXHIBIT OF 24TH

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Washington

Washington

Washington

1891-1892

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Washington

Washington County

John

Galvin

Monahan

June 15

20

White

April 18, 1917

Trucking

Wash. D.C.

U.S.A.

Driver

John Galvin Monahan Sr.

Rose Galvin

1891-1892 Mrs. Rose Monahan 1891-1892

No

June 18, 1891 Rose Hill Cemetery Washington D.C.

Monahan Funeral Home 1891-1892

1519
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
09063		CERTIFICATE OF DEATH						09055			
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR		
Annabelle			Moore			June Month 5 Day 1969 Year			1:45 P.M.		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR		
Female		White		10/15/00			68 YRS.		MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			Md.	
West Virginia		USA					WASHINGTON				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
HAGERSTOWN			WESTERN MD. STATE HOSPITAL			waitress					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		
Maryland			Frederick		Brunswick		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		9 W. Potomac St.		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
George			Kave			Bessie			Whittington		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT			Address			
No			215-26-8339		Mrs. Virginia Cooper - Pineville, Pa.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>Pulmonary embolism</u>										1 hour	
DUE TO, OR AS A CONSEQUENCE OF											
(b) <u>Left Phlebothrombosis, leg</u>										1 week	
DUE TO, OR AS A CONSEQUENCE OF											
(c) <u>Carcinoma of stomach</u>										7 months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
<u>Arteriosclerotic heart disease</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Yes				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
		HOUR A.M. Month Day Year P.M. 19									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) <u>this hospital</u> attended the deceased from <u>April 24</u> , 19 <u>69</u> , to <u>June 5</u> , 19 <u>69</u> , that (I) <u>do</u> do not know the deceased alive on <u>June 5</u> , 19 <u>69</u> , and that in (my) <u>own</u> own opinion death occurred on the date and hour and from the causes stated above, (I) <u>was</u> was (did) did not view the body after death.											
22b. SIGNATURE					DEGREE			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED	
<u>Chong Choon Han</u>										6/5/69	
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS						
Chong Choon Han, M.D.					Western Maryland State Hospital			1500 Pennsylvania Ave., Hagerstown, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town)		(County) (State)		
<u>Burial</u>		<u>6-9-69</u>		<u>Elmwood</u>			<u>Shepherdstown</u>		<u>md-wa</u>		
24. FUNERAL DIRECTOR					ADDRESS			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
<u>Feete Funeral Home Brunswick</u>					<u>md</u>			JUN 10 1969		<u>Richard Judge</u>	

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800-85-7155

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FOR STATE
HEALTH DEPT.

09064

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09056

1. DECEASED-NAME (Type or Print) First Middle Last ROBERT Sidney MORRIS			2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> Month Day Year June 20, 1969			2b. HOUR 3:35 P.M.	
3. SEX male	4. RACE white	5. DATE OF BIRTH May 12, 1912	6. AGE (In years last birthday) 57 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD Month Day Year June 20, 1969	
7a. BIRTHPLACE (State or foreign country) Georgia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington County	
10. CITY OR TOWN OF DEATH Hagerstown			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Western Maryland St. Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life or if retired) Sheet Metal Worker	
12b. KIND OF BUSINESS OR INDUSTRY retired			13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) Maryland			13b. CITY OR TOWN Jakoma Pk.	
13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 7016 Sycamore Avenue				
14. FATHER'S NAME First Middle Last Alfred A. Morris			15. MOTHER'S MAIDEN NAME First Middle Last Margaret Shirley				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 578-01-9519			17. INFORMANT Lorene Morris, 7016 Sycamore Avenue.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE (ATELECTASIS) 189.0 DUE TO, OR AS A CONSEQUENCE OF CARCINOMA OF RIGHT KIDNEY WITH METASTASIS TO VERTEBRA (T1 & T2) WITH SPINAL CORD COMPRESSION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ONE YEAR
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE A. E. W. Ditto, Jr.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED June 21, 1969	
EXAMINER'S NAME (Type) Dr. E. W. Ditto, Jr.			M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE June 24, 1969		23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION (City or Town) (County) (State) Rockville, Maryland
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc.			ADDRESS 8434 Georgia Avenue Silver Spring, Maryland		25a. REC'D BY REGISTRAR JUN 27 1969		25b. REGISTRAR'S SIGNATURE Phelan Judge

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MD. 21201
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

32020

SPINAL CORD COMPRESSION
METASTASIS TO VERTEBRA (T1 & T2)
CARCINOMA OF RIGHT KIDNEY
RESPIRATORY FAILURE (ATELECTASIS)

X

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in on the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

09065

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09057

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR	
WILLIAM		RICHARD		MULLENIX, SR.	JUNE 23 69		5 p M	
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
MALE	WHITE		AUGUST 16, 1901		67 YRS.		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
MARYLAND		U.S.A.				WASHINGTON Md.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
KNOXVILLE		ROUTE #1		RETIRED PIPE FITTER		B & O RR		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER
MARYLAND		WASHINGTON		KNOXVILLE		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		ROUTE #1
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle Last
JACOB		S		MULLENIX	GERTRUDE		I	WIEBEL
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (no, or unknown) NO		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address		
		214-09-1723		MRS MAY L MULLENIX		ROUTE #1 KNOXVILLE, MARYLAND		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarct</u>								
4109 DUE TO, OR AS A CONSEQUENCE OF Coronary atherosclerosis								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF generalized arteriosclerosis								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Viral Gastro-enteritis</u>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
none		-		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
		19		none				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No. City or Town County State		
		none		-		-		
22a. I certify that (I) (this hospital) attended the deceased from <u>Aug</u> , 19 <u>61</u> , to <u>June 23</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>June 21</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>Harold R. Tritch, Jr.</u> MD				DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 6/24/69
22d. PHYSICIAN'S NAME (Type) H R TRITCH, JR.				22e. ADDRESS 302 N POTOMAC ST., HAGERSTOWN, MD.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
BURIAL		6/26/69		ROSE HILL CEMETERY		HAGERSTOWN, WASHINGTON, MD.		
24. FUNERAL DIRECTOR <u>Charles M. Leuger</u>				ADDRESS HAGERSTOWN, MARYLAND		25a. REC'D BY REGISTRAR JUN 30 1969		25b. REGISTRAR'S SIGNATURE <u>Charles M. Leuger</u>

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09066

CERTIFICATE OF DEATH

09058

1. DECEASED-NAME (Type or print) First Middle Last Robert Eugene Munson, Sr.			2a. DATE OF DEATH 6 Month 17 Day 69 Year		2b. HOUR M
3. SEX male	4. RACE white	5. DATE OF BIRTH 7-28-1920		6. AGE (In years last birthday) 48 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) Md.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED WIDOWED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Washington Md.		
10. CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Wash. Co. Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Inspector		12b. KIND OF BUSINESS OR INDUSTRY aircraft
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.	13b. COUNTY Wash.	13c. CITY OR TOWN Hagerstown	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 29 Coffman Ave.	
14. FATHER'S NAME First Middle Last Ernest F. Munson		15. MOTHER'S MAIDEN NAME First Middle Last Cora Saum			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16b. SOCIAL SECURITY NO. 219-05-4927	17. INFORMANT Address Ruth Munson Hagerstown, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the lung 1621 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) this hospital attended the deceased from 12/28 , 19 68 , to 6/17 , 19 69 , that (I) (we) last saw the deceased alive on 6/17 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Donald E. Martin, M.D. DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED 6/18/69	
22d. PHYSICIAN'S NAME (Type) Donald E. Martin, M.D. 22e. ADDRESS 363 S. Cleveland Ave., Hagerstown, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 6-20-69	23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Hagerstown, Md.	
24. FUNERAL DIRECTOR ADDRESS Minnich Funeral Home Hagerstown, Md.			25a. REC'D BY REGISTRAR JUN 23 1969	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

09068

CERTIFICATE OF DEATH

09068

Robert Eugene Jensen, Sr.

White

7-28-1920

Washington

USA

Ins. Co. (Medical)

Inspector

Register of

Death

Death

James T. Jensen

210-0-1957

Condition of the

Death

1957

6-20-00

Rose Hill Cemetery

Minneapolis, Minn.

Register of

777X

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
<div style="display: flex; justify-content: space-between;"> 109067 Item #13, Taken from birth cert. 074/69 km CERTIFICATE OF DEATH 10561 </div>											
1. DECEASED-NAME (Type or print) <u>Baby Girl</u>					2a. DATE OF DEATH					2b. HOUR	
<div style="display: flex; justify-content: space-between;"> First Middle Last </div>					<div style="display: flex; justify-content: space-between;"> Month Day Year </div>					<div style="display: flex; justify-content: space-between;"> 2 15 M </div>	
3. SEX <u>Female</u>		4. RACE <u>white</u>		5. DATE OF BIRTH <u>6-27-69</u>			6. AGE (In years lost birthday) <u>27</u> YRS.		<div style="display: flex; justify-content: space-between;"> IF UNDER 1 YEAR IF UNDER 24 HRS. </div>		
7a. BIRTHPLACE (State or foreign country) <u>Maryland</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Washington</u> Md.					
10. CITY OR TOWN OF DEATH <u>Hagerstown md.</u>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Washington Co. Hosp.</u>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Maryland</u>			13b. COUNTY <u>Washington</u>			13c. CITY OR TOWN <u>Clear Spring</u>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13e. STREET AND NUMBER <u>Route #1</u>			14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME					
<div style="display: flex; justify-content: space-between;"> First Middle Last </div>			<div style="display: flex; justify-content: space-between;"> First Middle Last </div>			<div style="display: flex; justify-content: space-between;"> First Middle Last </div>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <u>No</u>			16b. SOCIAL SECURITY NO. <u></u>			17. INFORMANT <u>Mother</u>			Address <u>Shirley Ann Weishard</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>Prematurity (5 mo old fetus)</u>											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) <u></u>											
DUE TO, OR AS A CONSEQUENCE OF											
(c) <u></u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>6/27</u> , 19 <u>69</u> , to <u>6/27</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>6/27</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Harold R. Tritch Jr MD</u> DEGREE						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <u>6/27/69</u>		
22d. PHYSICIAN'S NAME (Type) <u>HAROLD R. Tritch Jr MD</u>						22e. ADDRESS <u>302 N. Potomac St Hagerstown Md</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>			23b. DATE <u>7-30-69</u>			23c. NAME OF CEMETERY OR CREMATORY <u>UNIVERSITY OF PITTSBURGH</u>			23d. LOCATION (City or Town) (County) (State)		
24. FUNERAL DIRECTOR <u>W. J. ...</u> ADDRESS						25a. REC'D BY REGISTRAR <u>AUG 4 1969</u>			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

00001

UNIVERSITY OF TORONTO

Library of the
University of Toronto
100 St. George Street
Toronto, Ontario
M5S 1A5

George W. Morgan
100 St. George Street
Toronto, Ontario
M5S 1A5

UNIVERSITY OF TORONTO
LIBRARY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

4121

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09068

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09059

1. DECEASED-NAME (Type or print) First Middle Last <i>John William Myers</i>			2a. DATE OF DEATH Month Day Year <i>June 13 1969</i>			2b. HOUR <i>7:20 PM</i>			
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>Sept. 11, 1888</i>		6. AGE (In years last birthday) <i>80</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <i>Dry Run, Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Washington</i> Md.			
10. CITY OR TOWN OF DEATH <i>Hagerstown</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Washington Co. Hospital</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Mfg. Pipe Organ</i>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Washington</i>		13c. CITY OR TOWN <i>Hagerstown</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>R # 2 Resh Road</i>	
14. FATHER'S NAME First Middle Last <i>Benjamin Franklin Myers</i>				15. MOTHER'S MAIDEN NAME First Middle Last <i>Rebecca Daley</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16b. SOCIAL SECURITY NO. <i>214-09-1196</i>		17. INFORMANT Address <i>Mr. Robert E. Myers Sr. R # 2 Hagerstown, Md.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Nephrosclerosis</i> <i>5</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Hypertensive Arteriosclerotic Heart Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>4121</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>7 months</i> <i>Unknown</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>None</i>									
19a. DATE OF OPERATION <i>None</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>YES</i>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (the hospital) attended the deceased from <i>Nov. 4, 1968</i> to <i>June 13, 1969</i> , that (I) (we) saw the deceased alive on <i>June 13, 1969</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Archie Robert Cohen</i>				DEGREE <i></i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>06/15/69</i>	
22d. PHYSICIAN'S NAME (Type) <i>Archie Robert Cohen, M.D.,</i>				22e. ADDRESS <i>Clear Spring, Maryland</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>6/17/69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Rest Haven Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Hagerstown-Washington-Md.</i>			
24. FUNERAL DIRECTOR <i>Wm. G. Host</i>				ADDRESS <i>Rest Haven Funeral Chapel Hagerstown, Md.</i>		25a. REC'D BY REGISTRAR <i>JUN 19 1969</i>		25b. REGISTRAR'S SIGNATURE <i></i>	

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214-02-1190 - Robert L. White, Jr. & Co. Incorporated, Inc.

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FOR STATE
HEALTH DEPT.

09069

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09060

1. DECEASED-NAME (Type or Print)			First RAYMOND			Middle LEE			Last MYERS			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> June 30 1969			2b. HOUR 11 P.M.						
3. SEX Male		4. RACE White		5. DATE OF BIRTH March 30 1930		6. AGE (In years last birthday) 39 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS HOURS 0 MIN. 0		2c. DATE PRONOUNCED DEAD Month June Day 30 Year 1969			2d. HOUR 11:55 P.M.						
7a. BIRTHPLACE (State or foreign country) Maryland				7b. CITIZEN OF WHAT COUNTRY? Washington U.S.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH Washington									
10. CITY OR TOWN OF DEATH Hagerstown						11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) RURAL Garrig Shop Road Hagerstown						12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.) Contractor				12b. KIND OF BUSINESS OR INDUSTRY Roads					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md						13b. COUNTY Washington						13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Garrig Shop Road (RFD3)					
14. FATHER'S NAME First Hubert Middle Myers Last Myers						15. MOTHER'S MAIDEN NAME First Mazie Middle Kesselring Last Kesselring															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give war or dates of service) Korean War						16b. SOCIAL SECURITY NO. 220-30-9151						17. INFORMANT ADDRESS Mr. Hubert Myers Jr. Funkstown Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wound of upper rt. quadrant of abdomen at costal margin right of nipple line. DUE TO, OR AS A CONSEQUENCE OF (b) nipple line. DUE TO, OR AS A CONSEQUENCE OF (c) last. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Instant							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																					
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>						21b. TIME OF INJURY Month, Day, Year 11 P.M. June 30, 1969						21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Shot by wife.									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>						21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home						21f. LOCATION Street or R.F.D. No. City or Town County State R.F.D. 3, Hagerstown, Washington, Md.									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>																					
ACTUAL SIGNATURE Dr. E. W. Ditto, Jr.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>						22b. DATE SIGNED 7-2-69									
EXAMINER'S NAME (Type) Dr. E. W. Ditto, Jr.						M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial						23b. DATE July 3-69						23c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery									
24. FUNERAL DIRECTOR Mr. Albert L. Leqf Williamsport, Md.						ADDRESS 215 W. Washington St., Hagerstown, Md.						25a. REC'D BY REGISTRAR DATE UL 3 1969									
												25b. REGISTRAR'S SIGNATURE William L. Under									

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

2020



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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09070

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

09061

1. DECEASED-NAME (Type or print) First Middle Last Howard Nelson Naugle			2a. DATE OF DEATH Month Day Year June 30, 1969			2b. HOUR 12:30 A.M.			
3. SEX male		4. RACE white		5. DATE OF BIRTH July 21, 1896		6. AGE (In years last birthday) 72 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Penna.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington Md.			
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Wash. Co. Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Prod. Engr.		12b. KIND OF BUSINESS OR INDUSTRY Mfg. Co.			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Penna.		13b. COUNTY Franklin		13c. CITY OR TOWN Waynesboro		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 209A. Elder Ave.	
14. FATHER'S NAME First Middle Last A. J. Naugle			15. MOTHER'S MAIDEN NAME First Middle Last Ellen Lowans						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 73-03-0691		17. INFORMANT Mrs. Howard Naugle, Waynesboro, Pa.			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary atherosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Generalized atherosclerosis</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION 6/24/69		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED. Bypass graft with generalized atherosclerosis			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 6/11, 1969, to 6/30, 1969, that (I) (we) last saw the deceased alive on 6/29, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE John R. Marsh					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 7/2/69		
22d. PHYSICIAN'S NAME (Type) John R. Marsh, Md.					22e. ADDRESS 247 N. Potomac St., Hagerstown, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7-2-69		23c. NAME OF CEMETERY OR CREMATORY Green Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Waynesboro, Pa.			
24. FUNERAL DIRECTOR Poe Funeral Home, Waynesboro, Pa.					25a. REC'D BY REGISTRAR DATE JUL 7 1969		25b. REGISTRAR'S SIGNATURE M. L. ...		

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1901 MAR 24 - SAT

RECEIVED THE CHIEF OF POLICE, NEW YORK CITY

Howard Nelson Bangle June 30, 1901

July 21, 1900

Washington

Legation, French Consulate, 209, Market Ave.

French Consulate, 209, Market Ave.

French Consulate, 209, Market Ave.

17-02-0591 Mr. Howard Bangle, Wynessboro, N.Y.

Dear Sir:

I have the honor to acknowledge the receipt of your letter of the 17th inst.

and in reply to inform you that the same has been forwarded to the proper authorities.

I am, Sir, very respectfully,
Yours,
J. H. [Signature]

Very truly,
J. H. [Signature]

Very truly,
J. H. [Signature]

Very truly,
J. H. [Signature]

Very truly,
J. H. [Signature]

Very truly,
J. H. [Signature]

Very truly,
J. H. [Signature]

Very truly,
J. H. [Signature]

Very truly,
J. H. [Signature]

Very truly,
J. H. [Signature]

Very truly,
J. H. [Signature]

FOR STATE
HEALTH DEPT.

09071

Item #24, Film 4114 7 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09062

1. DECEASED-NAME (Type or Print)			First Maude			Middle V.			Last Naylor			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year June 29, 1969			2b. HOUR 8:15		
3. SEX Female		4. RACE White		5. DATE OF BIRTH 11/11/1888		6. AGE (in years last birthday) 80 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD Month Day Year June 29, 1969			2d. HOUR 8:15		
7a. BIRTHPLACE (State or foreign country) Penna.				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH Washington Co. Md.					
10. CITY OR TOWN OF DEATH Hagerstown				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington Co., Hospital				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Nurse's Aid				12b. KIND OF BUSINESS OR INDUSTRY Hospital					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.				13b. COUNTY Washington				13c. CITY OR TOWN Highfield		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER					
14. FATHER'S NAME First Middle Last Charles R. P. Cline			15. MOTHER'S MAIDEN NAME First Middle Last Alice McClain			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No.						16b. SOCIAL SECURITY NO. 219-36-2829A		17. INFORMANT ADDRESS Mrs. Harry E. Harbaugh, Highfield Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (c) Fracture Of Left Pubic Bone & Ischium														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Several years 11 day's			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 6-18-1969				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Fall in her home.									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home				21f. LOCATION Street or R.F.D. No. City or Town County State Highfield, Washington, Maryland									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE Dr. E. W. Ditto, Jr.				EXAMINER'S NAME (Type) Dr. E. W. Ditto, Jr.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				22b. DATE SIGNED June 30, 1969					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE 7/2/69		23c. NAME OF CEMETERY OR CREMATORY Bethel				23d. LOCATION (City or Town) (County) (State) Lantz #1, Frederick Md.							
24. FUNERAL DIRECTOR David G. Groves Funeral Home, South Broad Street								25a. REC'D BY REGISTRAR JUL 3 1969				25b. REGISTRAR'S SIGNATURE Charles Judge					

4123

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
09072										
09063										
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH			2b. HOUR		
FLETCHER NOWELL OVELMAN					JUNE Month 28 Day 69 Year			8 a M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		
MALE		WHITE		MARCH 11, 1889		80 YRS.		MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
PENNSYLVANIA		U.S.A.				WASHINGTON Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
HAGERSTOWN			615 W CHURCH STREET			RETIRED MACHINIST		LANDIS TOOL CO.		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND			WASHINGTON		HAGERSTOWN		YES		615 W CHURCH STREET	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last							
WILLIAM C OVELMAN			LILLY BELLE KUHN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT		615 Address W CHURCH ST			
			183-07-4174A		MRS NELLIE OVELMAN		HAGERSTOWN, MARYLAND			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) <u>Pulmonary fibrosis</u>										
DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										
(b) <u>pulmonary hypertension</u>										
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
<u>Generalized atherosclerosis</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State		
22a. I certify that (I) <u>did not</u> attend the deceased from <u>Jan 13</u> , 19 <u>66</u> , to <u>June 28</u> , 19 <u>67</u> , that (I) <u>did</u> last saw the deceased alive on <u>May 28</u> , 19 <u>67</u> , and that in (my) <u>best</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>did</u> (did not) view the body after death.										
22b. SIGNATURE <u>Lawrence L Packer, Jr.</u>					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 6/30/69			
22d. PHYSICIAN'S NAME (Type) LAWRENCE L PACKER, JR., M.D.					22e. ADDRESS 145 W WASHINGTON ST., HAGERSTOWN, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
BURIAL		7/2/69		REST HAVEN CEMETERY		HAGERSTOWN, WASHINGTON, MD.				
24. FUNERAL DIRECTOR <u>Charles M. Reager</u>					ADDRESS HAGERSTOWN, MARYLAND		25a. REC'D BY REGISTRAR <u>JUL 2 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles M. Reager</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

09073										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										09064																																																	
1. DECEASED-NAME (Type or print)										First Middle Last										2a. DATE OF DEATH Month Day Year										2b. HOUR A																																							
BERTHA										EMMABELLE										PANGLE										June 4 1969										720 M																													
3. SEX										4. RACE										5. DATE OF BIRTH										6. AGE (in years last birthday)										YEARS										IF UNDER 1 YEAR MONTHS DAYS										IF UNDER 24 HRS. HOURS MIN									
Female										White										Sept 21 1885										83																																							
7a. BIRTHPLACE (State or foreign country)										7b. CITIZEN OF WHAT COUNTRY?										B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH																																							
Virginia										U.S.A.																				Washington																																							
10. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)										12a. USUAL OCCUPATION (Kind of work done during last of working life, even if retired.)										12b. KIND OF BUSINESS OR INDUSTRY																																							
Hagerstown										Jackson Conv. Home										Housewife										Own Home																																							
13a. USUAL RESIDENCE (Where deceased admission) STATE										13b. COUNTY										13c. CITY OR TOWN										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e. STREET AND NUMBER																													
Maryland										Washington										Hagerstown										YES										203 Roessner Ave																													
14. FATHER'S NAME										First Middle Last										15. MOTHER'S MAIDEN NAME										First Middle Last																																							
Charles Stafford																				Annie Mills																																																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)										(If yes give war or dates of service)										16b. SOCIAL SECURITY NO.										17. INFORMANT										Address										Md																			
No										---										220-46-1547										Mr Lawrence M. Sweeney Williamsport																																							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										PART 1. DEATH WAS CAUSED BY:										IMMEDIATE CAUSE (a)										DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																													
2509																				Cerebral hemorrhage										Dilated										5 years																													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																				(b)										Dilated										10 years																													
																				(c)																																																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																																																																					
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																																							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																																																	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																																																	
22a. I certify that (I) (this hospital) attended the deceased from 1-10, 1968, to 6-4, 1969, that (I) (we) last saw the deceased alive on 6-2-69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																																																					
22b. SIGNATURE										A. E. W. White Jr										DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c. DATE SIGNED										6-4-69																													
22d. PHYSICIAN'S NAME (Type)										A. E. W. White Jr										22e. ADDRESS										215 W Washington Hagerstown Md																																							
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION (City or Town) (County) (State)																																							
Burial										6/7/69										Rose Hill Cemetery										Hagerstown Wash. Co Md.																																							
24. FUNERAL DIRECTOR										Hagerstown Md										ADDRESS										25a. REC'D BY REGISTRAR										25b. REGISTRAR'S SIGNATURE																													
Andrew K. Coffman										Funeral Home Inc																				JUN 9 1969										Charles Judge																													

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RECEIVED
JAN 4 1969
FBI - NEW YORK

TO : DIRECTOR, FBI
FROM : SAC, NEW YORK
SUBJECT: [illegible]

RE: [illegible]

1. [illegible]

2. [illegible]

3. [illegible]

4. [illegible]

5. [illegible]

6. [illegible]

7. [illegible]

8. [illegible]

9. [illegible]

10. [illegible]

11. [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

09074										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										09065																																							
1. DECEASED-NAME (Type or print)										First Middle Last										2a. DATE OF DEATH Month Day Year										2b. HOUR M																													
ROY										HAYSE										PARLETT										June 7 1969										7																			
3. SEX Male										4. RACE White										5. DATE OF BIRTH July 27 1886										6. AGE (In years lost birthday) 82 YRS.										IF UNDER 1 YEAR MONTHS DAYS HOURS MIN										IF UNDER 24 HRS. HOURS MIN									
7a. BIRTHPLACE (State or foreign country) Penna										7b. CITIZEN OF WHAT COUNTRY? U.S.A.										8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH Washington										Md.																			
10. CITY OR TOWN OF DEATH Hagerstown										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Garlock Conv. Home										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Auto Mechanic										12b. KIND OF BUSINESS OR INDUSTRY Retired																													
13a. USUAL RESIDENCE (Where deceased admission) STATE Maryland										13b. COUNTY Washington										13c. CITY OR TOWN Hagerstown										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e. STREET AND NUMBER 536 George St																			
14. FATHER'S NAME First Middle Last David Hayse										15. MOTHER'S MAIDEN NAME First Middle Last Cora Reed																																																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No										(If yes give war or dates of service) ---										16b. SOCIAL SECURITY NO. 214-09-7596										17. INFORMANT Mrs Beverly Shanholtz										Address 536 George St																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) 4123 CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF (c)										Hagerstown Md.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months																																							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										CHRONIC URINARY TRACT INFECTION & SUPRAPUBIC CYSTOSTOMY																																																	
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																																							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																																							
22a. I certify that (I) (the hospital) attended the deceased from 4/1, 1967, to 6/7, 1969, that (I) (the) last saw the deceased alive on 6/6, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.																																																											
22b. SIGNATURE Donald E. Martin										22c. DATE SIGNED 6/9/69																																																	
22d. PHYSICIAN'S NAME (Type) Donald E. Martin, M.D.										22e. ADDRESS 363 S. Cleveland Ave., Hagerstown, Md.																																																	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial										23b. DATE 6/11/69										23c. NAME OF CEMETERY OR CREMATORY Shanktown Cemetery										23d. LOCATION (City or Town) (County) (State) Shanktown Wash Co Md.																													
24. FUNERAL DIRECTOR Andrew K. Coffman										Funeral Home Inc										25a. REC'D BY REGISTRAR JUN 11 1969										25b. REGISTRAR'S SIGNATURE Charles Judge																													

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Andrew A. Colman
Shawtown Cemetery
Shawtown, Ohio
July 11, 1988

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

09075		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				09066			
1. DECEASED-NAME (Type or print) First Middle Last MARY MILLER PATRICK						2a. DATE OF DEATH Month Day Year June 11 1969		2b. HOUR M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH Sept. 24, 1889		6. AGE (In years last birthday) 79 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington Md.			
10. CITY OR TOWN OF DEATH Williamsport		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Homewood Church Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE R.R. # 5 Md.		13b. CITY OR TOWN Washington		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Hagerstown			
14. FATHER'S NAME First Middle Last Joseph G. Miller				15. MOTHER'S MAIDEN NAME First Middle Last Margaret Agnew					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. 220-52-2156		17. INFORMANT Williamsport, Md 21795 Mark G. Wagner, Supt. 2750 Va. Av					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 4122 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) hypertensive CV Dis DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days 8 yrs.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from Aug 15, 1969 to 6-11, 1969 , that (I) (we) last saw the deceased alive on 6-10, 1969 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Robert P. Conrad, MD DEGREE Robert P. Conrad, MD					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 6-12-69		
22d. PHYSICIAN'S NAME (Type) Robert P. Conrad, MD					22e. ADDRESS Hagerstown, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6/13/69		23c. NAME OF CEMETERY OR CREMATORY Green Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Waynesboro, Penna.			
24. FUNERAL DIRECTOR Hagerstown, Md. Coffman Funeral Home, Inc					25a. RECD BY REGISTRAR JUN 16 1969 DATE		25b. REGISTRAR'S SIGNATURE William J. Judge		

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DEPARTMENT OF HEALTH

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[Faint, illegible handwritten notes and signatures covering the lower half of the page.]

Corbett Funeral Home, Inc.
Hagerstown, Md.
11 1902
Burial 11 1902
Hagerstown, Md.
11 1902

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
09076		MEDICAL EXAMINER'S CERTIFICATE OF DEATH						09067	
1. DECEASED-NAME (Type or Print)		First CHARLES		Middle FRANKLIN		Last PENTZ		2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 6 2 1969 11:00 P.M.	
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH 8/15/1913		6. AGE (In years last birthday) 55 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH WASHINGTON		2c. DATE PRONOUNCED DEAD Month 6 Day 7 Year 1969 11:00 P.M.	
10. CITY OR TOWN OF DEATH HAGERSTOWN		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WASHINGTON CO. HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) MACHINIST		12b. KIND OF BUSINESS OR INDUSTRY AIRCRAFT MFG.			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY WASHINGTON		13c. CITY OR TOWN HAGERSTOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 251 S. POTOMAC ST.	
14. FATHER'S NAME First Middle Last FRANK WESLEY PENTZ		15. MOTHER'S MAIDEN NAME First Middle Last LAURA EVERS GOSSARD		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) W.W.#2 219-09-3403		17. INFORMANT ADDRESS MR. FRANK W. PENTZ HAGERSTOWN MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thrombosis / Pulmonary Cerebral artery</u> DUE TO, OR AS A CONSEQUENCE OF <u>and</u> (b) <u>Advanced fatty metamorphosis liver</u> DUE TO, OR AS A CONSEQUENCE OF <u>and</u> (c) <u>Acute alcoholic intoxication</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>resolved.</u> (1) <u>Advanced pulmonary emphysema</u> (2) <u>Old subdural hemorrhage - grossly</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Indef. Indef. Indef.	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE EXAMINER'S NAME (Type) EDWARD W. DITTO, III, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED 6-8-69 217 W. WASHINGTON ST. HAGERSTOWN, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 6/11/69		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEM.		23d. LOCATION (City or Town) (County) (State) GREENCASTLE FRANKLIN PA.			
24. FUNERAL DIRECTOR W. J. Normant, Hagerstown, Md.		25a. REC'D BY REGISTRAR DATE JUN 13 1969		25b. REGISTRAR'S SIGNATURE Charles Judge					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
09077											
CERTIFICATE OF DEATH											
09068											
1. DECEASED-NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH Month Day Year		
Flora			Jane		Peterman		June		9 1969		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		2b. HOUR		
Female		White		August 21, 1871			97 YRS.		3:35 PM		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Hancock, Md.		U.S.A.		#		Washington Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Hagerstown, Md.			Wash. Co. Hospital			Home duties			House work		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER		
Maryland			Washington		Clear Spring #		NO		# Cumberland St.		
14. FATHER'S NAME			First		Middle		Last		15. MOTHER'S MAIDEN NAME		
Calvin			#		Zimmerman		Sarah		# Winger		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address		
No			None		219-54-1000		Walter W. Peterman		Clear Spring, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:										3 weeks	
IMMEDIATE CAUSE (a) Uremia											
4121 DUE TO, OR AS A CONSEQUENCE OF											
(b) Hypertensive Arteriosclerotic heart disease										??	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
Carcinoma breast, right, with Metastasis... Pernicious anemia											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
None						YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
		HOUR A.M. Month Day Year P.M. 19									
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION							
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>				Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (the hospital) attended the deceased from May 19, 1969, to June 9, 1969, that (I) (we) last saw the deceased alive on June 9, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		22c. DATE SIGNED									
Archie Robert Cohen M.D.		June 10, 1969									
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS									
Archie Robert Cohen, M.D.		Clear Spring, Maryland 21722									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		6/12/69		Methodist Church Cem.		Little Cove, Pa.					
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Margaret Rowland		JUN 16 1969		Charles Judge							
Clear Spring, Md.											

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UNITED STATES DEPARTMENT OF JUSTICE

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FOR STATE
HEALTH DEPT.

09078

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09069

1. DECEASED-NAME (Type or Print) ^{First} <u>MARCUS</u> ^{Middle} <u>ROY</u> ^{Last} <u>PETRE</u>						2a. DATE KNOWN OF ESTI-DEATH MATED <input checked="" type="checkbox"/> Month <u>June</u> Day <u>24</u> Year <u>1969</u>			2b. HOUR <u>8:35</u> P.M.		
3. SEX <u>M</u>		4. RACE <u>W</u>		5. DATE OF BIRTH <u>3/17/1967</u>		6. AGE (In years last birthday) <u>2</u> YRS. <u>3</u> MONTHS <u>7</u> DAYS		IF UNDER 1 YEAR		IF UNDER 24 HRS	
7a. BIRTHPLACE (State or foreign country) <u>Md.</u>				7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Washington</u>	
10. CITY OR TOWN OF DEATH <u>Hagerstown</u>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Wash. Co. Hosp.</u>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>NONE</u>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if in institution; Residence before admission) <u>Md.</u>				13b. COUNTY <u>WASH.</u>				13c. CITY OR TOWN <u>Rural</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME ^{First} <u>ROY</u> ^{Middle} <u>HORST</u> ^{Last} <u>PETRE</u>				15. MOTHER'S MAIDEN NAME ^{First} <u>MARTHA</u> ^{Middle} <u>EMMA</u> ^{Last} <u>RUDOLPH</u>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16b. SOCIAL SECURITY NO. <u>NONE</u>				17. INFORMANT <u>Roy A. Petre - RD3 - Hagerstown, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Compound Fracture Of Skull</u> <u>883X</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1/2</u> hour	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year <u>5:35 P.M. 6-24-1969</u>				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <u>Fell in unloading silo auger.</u>			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <u>Farm</u>				21f. LOCATION Street or R.F.D. No. <u>Route 3,</u> City or Town <u>Hagerstown,</u> County <u>Washington,</u> State <u>Maryland</u>			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>A. E. W. Ditto, Jr.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED <u>June 25, 1969</u>			
EXAMINER'S NAME (Type) <u>Dr. E. W. Ditto, Jr.</u>				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
23a. BURIAL CREMATION <u>Burial</u>				23b. DATE <u>6/27/69</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Reiff Church Cem.</u>			
24. FUNERAL DIRECTOR <u>A. E. Munnich - Greencastle Pa.</u>				ADDRESS <u>215 W. Washington St., Hagerstown, Md.</u>				25a. REC'D BY REGISTRAR <u>JUN 30 1969</u>			
								25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MD. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3.

5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

THE STATE
OF NEW YORK



03078

OFFICE OF THE ATTORNEY GENERAL

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IN SENATE
JANUARY 12, 1912

REPORT OF THE

COMMISSIONERS OF THE LAND OFFICE

FOR THE YEAR 1911

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THE UNIVERSITY OF THE STATE OF NEW YORK

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PRINTED BY THE UNIVERSITY OF THE STATE OF NEW YORK

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

09079										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										09070														
1. DECEASED-NAME (Type or print) Pauline Catherine Davis Philpot										2a. DATE OF DEATH D June Month 8 Day 1969 Year										2b. HOUR 10:30														
3. SEX Female					4. RACE White					5. DATE OF BIRTH 3/26/11					6. AGE (In years lost birthday) 58 YRS.					IF UNDER 1 YEAR MONTHS DAYS					IF UNDER 24 HRS. HOURS MIN									
7a. BIRTHPLACE (State or foreign country) Maryland					7b. CITIZEN OF WHAT COUNTRY? USA					8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH WASHINGTON Md.																			
10. CITY OR TOWN OF DEATH HAGERSTOWN					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WESTERN MD. STATE HOSPITAL					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) desk clerk					12b. KIND OF BUSINESS OR INDUSTRY																			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland					13b. COUNTY Prince George's					13c. CITY OR TOWN Bowie					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e. STREET AND NUMBER 12417 Shawmont Ave.														
14. FATHER'S NAME Arthur S. Davis					15. MOTHER'S MAIDEN NAME Lillian Rhodes					16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No										16b. SOCIAL SECURITY NO. 578-09-5534					17. INFORMANT Ave., Md., Wash., D.C. Mrs. Bernadeen D. Hershman, Sister, 3701 Conn.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure 491X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic bronchitis DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week 3 years																								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Multiple sclerosis																																		
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State																								
22a. I certify that (X) (this hospital) attended the deceased from Sept. 12, 1966 , to June 8, 1969 , that (I) (we) lost saw the deceased alive on June 8, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																		
22b. SIGNATURE Domingo A. Garcia										DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>					22c. DATE SIGNED 6/9/69																			
22d. PHYSICIAN'S NAME (Type) Domingo A. Garcia, M.D.										22e. ADDRESS Western Md. State Hospital, 1500 Pennsylvania Ave., Hagerstown, Md.																								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE 6-11-1969					23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery					23d. LOCATION (City or Town) (County) Colmar Manor, Prince Georges Co Maryland																			
24. FUNERAL DIRECTOR JOSEPH GAWLER'S SON, INC. 5130 WISC. AVE., N. W. WASH., D. C. 20016										25a. REC'D BY REGISTRAR JUN 12 1969 DATE					25b. REGISTRAR'S SIGNATURE Blanche Lodge																			

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Mr. Berntson D. Larsson, 1901

0305-1-1-0

For more information, contact:

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FOR STATE
HEALTH DEPT.

09080

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09071

1. DECEASED NAME (Type or Print) Earl Francis Reid, Jr.			2a. DATE KNOWN <input checked="" type="checkbox"/> Month Day Year OF ESTI. DEATH MATED <input type="checkbox"/> June 23, 1969			2b. HOUR 4:30 P. M.	
3. SEX Male	4. RACE White	5. DATE OF BIRTH Dec. 7, 1928	6. AGE (in years last birthday) 40 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD Month Day Year June 23, 1969	
7a. BIRTHPLACE (State or foreign country) Penna.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington Md.	
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington County Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Welder		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE W.Va.		13b. COUNTY Berkeley		13c. CITY OR TOWN Martinsburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last Earl F. Reid		15. MOTHER'S MAIDEN NAME First Middle Last Anna Amelia Treese					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		(If yes give war or dates of service) W.W.II		16b. SOCIAL SECURITY NO. 235-32-0895		17. INFORMANT ADDRESS Miss Anna Louise Reid-Morgantown, W.Va.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock 816.9 DUE TO, OR AS A CONSEQUENCE OF Due to severance of Rt. femoral Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) artery & vein; ruptured bladder; fractured DUE TO, OR AS A CONSEQUENCE OF pelvis; massive loss of blood. (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 46 hours
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				2D. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year 11:52 P.M. 6-21-69		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 2, Item 18.) Speeding auto crashed into pole.			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Street, River bottom Park entrance W. Salisbury St., Williamsport, Md.		21f. LOCATION Street or R.F.D. No. City or Town State Washington			
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE A. E. W. Ditto, Jr.		EXAMINER'S NAME (Type) Dr. E. W. Ditto, Jr.		22b. DATE SIGNED June 24, 1969		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6-25-69		23c. NAME OF CEMETERY OR CREMATORY Rosedale Cemetery		23d. LOCATION (City or Town) (County) (State) Martinsburg Berkeley W.Va.	
24. FUNERAL DIRECTOR Brown Funera 1 Home,		ADDRESS Martinsburg, W.Va.		25a. REC'D BY REGISTRAR JUN 26 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL CERTIFICATION

5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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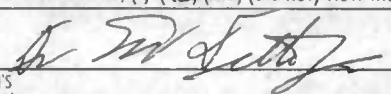

MEDICAL EXAMINATION REPORT

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

09081				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				09072					
Item 13 Film 414 7/14/69 kk				CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) EMMA				First Middle Last GAINES				2a. DATE OF DEATH Month Day Year June 29 1969				2b. HOUR 11 A. M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH December 25, 1876		6. AGE (In years last birthday) 92 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington Md.							
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 837 Lanvale Street				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housework		12b. KIND OF BUSINESS OR INDUSTRY Own Home					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 426 Salem Avenue					
14. FATHER'S NAME First Middle Last Cornelius Ridenour				15. MOTHER'S MAIDEN NAME First Middle Last Anna Edmonds									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If give war or dates of service) No		16b. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs Margaret Itnyre 837 Lanvale St.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Arteriosclerosis 4124 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardio Vascular Disease, Severe DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Several years			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that (I) (this hospital) attended the deceased from Jan. , 19 67 , to June 29 , 19 69 , that (I) (we) lost saw the deceased alive on June 24 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE 				DEGREE Dr. E. W. Ditto, Jr.		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 7-1-69			
22d. PHYSICIAN'S NAME (Type) Dr. E. W. Ditto, Jr.				22e. ADDRESS 215 W. Washington St., Hagerstown, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7/7/69		23c. NAME OF CEMETERY OR CREMATORY Funkstown Cemetery				23d. LOCATION (City or Town) (County) (State) Funkstown Washington Md.					
24. FUNERAL DIRECTOR Hagerstown Md.						ADDRESS Andrew K. Coffman Funeral Home Inc.		25. REC'D BY REGISTRAR JUL 7 1969		25b. REGISTRAR'S SIGNATURE 			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please re-leave carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										09073	
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH		2b. HOUR				
ALEJANDRO ROBLES RODRIGUEZ					JUNE 24 1969		1030 PM				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 MRS.	
MALE		BLANCO White		AUGUST 26 1903		65 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
BOLIVIA		BOLIVIA				WASHINGTON Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
HAGERSTOWN			WASHINGTON COUNTY HOSPITAL			INSPECTOR			AIRCRAFT		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
MARYLAND			WASHINGTON			HAGERSTOWN		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		2374 PENNSYLVANIA AVE.	
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME						
UNKNOWN					RODRIGUEZ						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT						
NO			NONE		GUIDO O'CONNOR 3030 PEDRO BLANCO ST. COCHABAMBO BOLIVIA						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypoproteinemia & anemia, severe.</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Acute Renal Failure</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>2 days</u> <u>Unknown</u>	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) XXXXXX attended the deceased from <u>6/23</u> , 19 <u>69</u> , to <u>6/24</u> , 19 <u>69</u> , that (I) (we) saw the deceased alive on <u>6/24</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Francisco G. Japzon, MD.</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>6/26/69</u>			
22d. PHYSICIAN'S NAME (Type) <u>FRANCISCO G JAPZON M.D.</u>						22e. ADDRESS <u>580 Northern Avenue, Hagerstown, MARYLAND</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
REMOVAL			<u>6-27-69</u>			CEMETERY GENERAL			COCHABAMBA BOLIVIA		
24. FUNERAL DIRECTOR <u>Charles M. Leuzer</u>						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
HAGERSTOWN MARYLAND						DATE <u>JUN 30 1969</u>		<u>Charles M. Leuzer</u>			

Visto en este Consulado de
Bolivia en Washington, D.C.

Junio 26, 1969



7769

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) First Middle Last Sabato Jean Marie						2a. DATE OF DEATH - Month Day Year June 1 1969			2b. HOUR 1:50 A.M.		
3. SEX Female		4. RACE White		5. DATE OF BIRTH 5-31-69		6. AGE (In years last birthday) YRS.		IF UNDER 1 YEAR MONTHS DAYS 7 5		IF UNDER 24 HRS. HOURS MIN. 7 5	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington County Md.					
10. CITY OR TOWN OF DEATH Hagerstown			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington County Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Washington		13c. CITY OR TOWN Cascade		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Box 86		
14. FATHER'S NAME First Middle Last John m. Sabato				15. MOTHER'S MAIDEN NAME First Middle Last Alexius Jean Overton							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (no, or unknown)		16b. SOCIAL SECURITY NO. (If you give war or dates of service)		17. INFORMANT Spc. 5 John M. Sabato				Address Box 86 Cascade Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Stab wounds - severe 7769 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Prematurity Feb 15 age DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 hrs 5 min	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 5/31/69 , 19 69 , to 6/1/69 , 19 69 , that (I) (we) lost saw the deceased alive on 5/31/1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE A. M. Bacon Jr. MD				DEGREE MD		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 6/1/69			
22d. PHYSICIAN'S NAME (Type) A. M. Bacon Jr.				22e. ADDRESS 101 King St., Hagerstown Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6/4/69		23c. NAME OF CEMETERY OR CREMATORY Holy Cross		23d. LOCATION (City or Town) (County) (State) Philadelphia, Philadelphia Pa					
24. FUNERAL DIRECTOR David Z. Grove				ADDRESS Waynesboro Pa.		25a. REC'D BY REGISTRAR JUN 4 1969		25b. REGISTRAR'S SIGNATURE Charles Jones			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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09084				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				09075			
1. DECEASED-NAME (Type or print)				2a. DATE OF DEATH				2b. HOUR			
Sanger, William Elmer				6 23 69 Month Day Year				805 P. M.			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Male		White		11/4/1876		92 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
W. Va.		USA				Washington Md.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
Boonsboro		Farnley-Keedy Mem. Home for Aged									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
Md.		Talbot		Cordova		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		rural			
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last							
Henry E. Sanger				Bettie Pobst							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Address							
no		unkn.		Roland Z. Sanger, Cordova, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cordoal Vascular</u> <u>4124</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>Aug</u> , 19 <u>68</u> , to <u>June</u> , 19 <u>69</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>June</u> , 19 <u>69</u> , and that in (<u>my</u>) (<u>our</u>) opinion death occurred on the date and hour and from the causes stated above, (I) (<u>we</u>) (did) (did not) view the body after death.											
22b. SIGNATURE <u>G. W. HeVan M.D.</u>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (Type) <u>G. W. HeVan M.D.</u>				22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		6/26/1969		Fairview		Cordova, Md.					
24. FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
MAURICE E. NEUNAM & SON, Easton, Md.				DATE JUN 25 1969		Charles Judge					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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09085		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				09076			
1. DECEASED-NAME (Type or print) First Middle Last Grace Virginia Schindel						2a. DATE OF DEATH 6 Month 30 Day 69 Year		2b. HOUR 6:18 P M	
3. SEX female		4. RACE white		5. DATE OF BIRTH May 31, 1909		6. AGE (In years last birthday) 60 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington Md.			
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Wash Co. Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) sewing mach. ap.		12b. KIND OF BUSINESS OR INDUSTRY dress mfg.			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Wash		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 729 Salem Ave.	
14. FATHER'S NAME First Middle Last Max G. Siebert				15. MOTHER'S MAIDEN NAME First Middle Last Jessie Shennebeck					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no		16b. SOCIAL SECURITY NO.		17. INFORMANT Charles Schindel		Address Hagerstown, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 Coronary Occlusion DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Cardiovascular not known DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerosis, General Not known								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 Mins.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Aspiration Pneumonia and Diabetes Mellitus									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 69		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from May 1, 19 69, to June 30, 19 69, that (I) (we) last saw the deceased alive on June 30, 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Arthur Siebert		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 6/30/69			
22d. PHYSICIAN'S NAME (Type) ARTHUR SIEBERT		22e. ADDRESS 119 E. Antietam Hagerstown							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7-3-69		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Hagerstown, Md.			
24. FUNERAL DIRECTOR ADDRESS Minnich Funeral Home Hagerstown, Md.				25a. REC'D BY REGISTRAR JUL 3 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

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CENTRAL OF DEAN

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Virginia, Shenandoah

May 21, 1908

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USA

Washington

Each Co. Hospital

Academy, Wash. D.C.

Gen. Hospital

222 21st Ave.

Mar. 21, 1908

Jessie Shannon

Charles Shenandoah, Wash. D.C.

Rose Hill Cemetery

Washington, D.C.

Final funeral home, Washington, D.C.

1908

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09086

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09077

1. DECEASED-NAME (Type or print) Charles E. Schwinger			2a. DATE OF DEATH Month June Day 3 Year 1969			2b. HOUR 6:30 AM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH June 20, 1906		6. AGE (In years last birthday) 62 YRS.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington	
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington County Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Shipping Clerk		12b. KIND OF BUSINESS OR INDUSTRY Mill Knitting	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Penna.		13b. COUNTY Franklin		13c. CITY OR TOWN Waynesboro		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 227 S. Broad St.		14. FATHER'S NAME First Middle Last Charles O. Schwinger		15. MOTHER'S MAIDEN NAME First Middle Last Minnie F. Ott			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) Yes		(If yes give war or dates of service) WW II		16b. SOCIAL SECURITY NO. 173-03-2209		17. INFORMANT Address Mrs. C. E. Schwinger 227 S. Broad St., Waynesboro, Pa.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 4339 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) adipose tissue heart							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 9-27-67 , 19 67 , to 6-2-69 , 19 69 , that (I) (we) last saw the deceased alive on 6-2-69 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE E. R. Lardizabal		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 6-3-69			
22d. PHYSICIAN'S NAME (Type) E. R. Lardizabal, M. D.		22e. ADDRESS 302 Locust St. Cleveland Ave. Hagerstown					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE June 5, 1969		23c. NAME OF CEMETERY OR CREMATORY Bethel		23d. LOCATION (City or Town) (County) (State) Lantz R.D.1, Frederick, Md.	
24. FUNERAL DIRECTOR Harold G. Gure		ADDRESS Waynesboro, Penna.		25a. REC'D BY REGISTRAR JUN 9 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

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Dr. J. F. Smith

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
09087					CERTIFICATE OF DEATH					09078				
1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HAGERSTOWN c. LENGTH OF STAY IN b 3 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Martin Manor Nursing Home 1222 Virginia Avenue					2. USUAL RESIDENCE (Where deceased lived; if institution, residence before admission) a. STATE WEST VIRGINIA b. COUNTY BERKELEY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HEDGESVILLE d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) EDNA First HOUSEHOLDER Last SHICKLE EDNA H. SHICKLE					4. DATE OF DEATH Month JUNE Day 13 Year 19 69									
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH AUG. 26, 1890		9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months 13 Days 13		IF UNDER 24 HRS. Hours 13 Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Duties					10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (County & State, or foreign country) York County, Pennsylvania			12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME John Thomas Householder					14. MOTHER'S MAIDEN NAME Magdekine Eisenhower									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No					16. SOCIAL SECURITY NO.		17. INFORMANT Ernest K. Shickle Address Hedgesville, W. Va.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Lobular Pneumonia 485 X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Arteriosclerosis, generalized & arteriosclerotic Heart Dis.										INTERVAL BETWEEN ONSET AND DEATH 4-5 days				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)								
21. I certify that (I) (this hospital) attended the deceased from June 1, 1966 , to June 13, 1969 , that (I) (we) last saw the deceased alive on June 12, 1969 , and that death occurred at 3:45 P.M. from the causes and on the date stated above.														
22a. SIGNATURE Edward W. Ditto, III M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED 6-13-69						
22c. PHYSICIAN'S NAME (Type) EDWARD W. DITTO, III, M.D.					22d. ADDRESS 217 W. WASHINGTON STREET HAGERSTOWN, MARYLAND									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 15, 69		23c. NAME OF CEMETERY OR CREMATORY Hedgesville Cemetery				23d. LOCATION (City, town or county) (State) Hedgesville, W. Va. 25427						
24. FUNERAL DIRECTOR'S SIGNATURE Howard K. Brown ADDRESS Martinsburg, W. Va. 25401					25a. REC'D BY REGISTRAR JUN 16 1969			25b. REGISTRAR'S SIGNATURE Richard A. Judge						

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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09088

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09079

1. DECEASED-NAME (Type or print)			First Elta	Middle Elizabeth	Last Smith	2a. DATE OF DEATH Month Day Year June 24, 1969			2b. HOUR 4:00 AM		
3. SEX Female		4. RACE White		5. DATE OF BIRTH March 28, 1882		6. AGE (In years last birthday) 87 YRS.		IF UNDER 1 YEAR MONTHS OAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Funkstown, Md.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington			Md.		
10. CITY OR TOWN OF DEATH Hagerstown			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Jackson Convalescent Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Own Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Washington		13c. CITY OR TOWN Funkstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 34 W. Baltimore St.		
14. FATHER'S NAME First Middle Last Jacob S. Stouffer			15. MOTHER'S MAIDEN NAME First Middle Last Adeline Harnish			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) No.					
16b. SOCIAL SECURITY NO. 220-144-9776			17. INFORMANT Mr. Frank S. Smith, Funkstown, Maryland			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis 4330 DUE TO, OR AS A CONSEQUENCE OF (b) cerebral arteriosclerosis (c) arteriosclerosis, general Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Arteriosclerotic heart disease, complete depression, Hypertensive Vasc. Disease					
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from January 1969, to June 1969, that (I) (we) last saw the deceased alive on 23 June 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Clovis M. Snyder			DEGREE M.D.			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 24 June 69		
22d. PHYSICIAN'S NAME (Type) Clovis M. Snyder, M.D.			22e. ADDRESS 1002 N. Potomac St., Hagerstown, Md.								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 6-26-69		23c. NAME OF CEMETERY OR CREMATORY Funkstown Cemetery			23d. LOCATION (City or Town) (County) (State) Funkstown, Wash. Co., Md.			
24. FUNERAL DIRECTOR John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.						25a. REC'D BY REGISTRAR JUN 27 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

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John F. Smith, Jr., 1112 N. Main St., Rochester, N.Y. 14601
Rochester, N.Y. 14601
Rochester, N.Y. 14601

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09089

CERTIFICATE OF DEATH

09080

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR		
JOSEPH HURST SMITH						JUNE 12 1969			2:00		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
MALE		WHITE		DECEMBER 15, 1914		54 YRS.		MONTHS		DAYS	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.			
MARYLAND		U.S.A.				WASHINGTON					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
HANCOCK		HIGH STREET		DENTIST							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13e. STREET AND NUMBER					
MARYLAND		WASHINGTON		HANCOCK		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		HIGH STREET			
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
ROYAL			HURST	SMITH	GENEVEIVE			EXLINE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address					
YES		W.W. 2		MILDRED F. SMITH, HAHG STREET HANCOCK							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>Coronary occlusion</u>										10 min	
DUE TO, OR AS A CONSEQUENCE OF <u>Coronary artery disease</u>										1 yem	
CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
					YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
		HOUR A.M. Month Day Year P.M. 19									
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town	County	State	
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>				Mar		59		6/12	69		
22a. I certify that (I) (this hospital) attended the deceased from <u>Mar</u> , 19 <u>59</u> , to <u>6/12</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>6/12</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE		ATTENDING PHYS.		MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED			
FB Thomas III M.D.								6/13/60			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS									
FB Thomas III M.D.		HANCOCK									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)	(State)		
BURIAL		6/14/69		ST. PETERS CATHOLIC		HANCOCK, WASHINGTON		MD.			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Kulind J. Grove		Hancock, Md.		JUN 16 1969		Charles Jones					

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OFFICE OF THE

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JOSEPH HURST SMITH JUNE 12 1900 2:00

MALE	WHITE	DECEMBER 12, 1919	WASHINGTON
MARYLAND	U.S.A.		
HANCOCK	HIGH STREET	DENTIST	
MARYLAND	WASHINGTON	HANCOCK	HIGH STREET
ROYAL	HURST SMITH	GENEVEVE	EXLINE
YES	U.S.A.	MILROD F. SMITH, HIGH STREET HANCOCK	

[Faint, illegible handwritten notes and stamps are visible in this section.]

ST. PETERS CATHOLIC HANCOCK, WASHINGTON, MD. 01/11/00

FOR STATE
HEALTH DEPT.

09090

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09081

1. DECEASED-NAME (Type or Print) CHARLES MARION SPRANKLE			2a. DATE KNOWN <input checked="" type="checkbox"/> Month Day Year June 28, 1969			2b. HOUR 9:15 P.		
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH 9/30/1912	6. AGE (In years last birthday) 56 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c. DATE PRONOUNCED DEAD Month Day Year June 28, 1969		
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH WASHINGTON		
10. CITY OR TOWN OF DEATH HAGERSTOWN			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital during last 24 hours) WASHINGTON CO. HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during last 24 hours, even if retired) SALESMAN		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) MARYLAND			13b. CITY OR TOWN HAGERSTOWN			13c. STREET AND NUMBER 46 BELVIEW AVE.		
14. FATHER'S NAME First Middle Last CHARLES CLIFFORD SPRANKLE			15. MOTHER'S MAIDEN NAME First Middle Last PEARL COX			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Type or unknown) YES (Type or number of service) W.W.#2		
16b. SOCIAL SECURITY NO.			17. INFORMANT MRS. FLORENCE L. SPRANKLE			ADDRESS HAGERSTOWN MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Brain Syndrome DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 887X (b) Cardiac Pulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF Pneumo thorax (c) Fractured Rib								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 26 day's
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 6-2- 19 69			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Fell in bathtub.		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home			21f. LOCATION Street or R.F.D. No. City or Town County State 46 Belview Ave., Hagerstown, Washington, Md.		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE E. W. Ditto, Jr.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED June 30, 1969		
EXAMINER'S NAME (Type) Dr. E. W. Ditto, Jr.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE 7/1/69			23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.		
24. FUNERAL DIRECTOR W. J. Norment, Hagerstown, Md.			ADDRESS			25a. REC'D BY REGISTRAR JUL 7 1969		
						25b. REGISTRAR'S SIGNATURE R. Charles Judge		
23d. LOCATION (City or Town) (County) (State) HAGERSTOWN WASH. MD.								

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MD. 21201
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-100. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH			2b. HOUR	
First Middle Last Leila T. Squillari					June Month 3 Day 1969			6:55 A M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR	
Female		White		2/5/90		79 YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
New Jersey		USA				WASHINGTON COUNTY Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
HAGERSTOWN		WESTERN MARYLAND STATE HOSPITAL				Housewife			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Allegany		Frostburg				252 West Mechanic St.	
14. FATHER'S NAME First Middle Last					15. MOTHER'S MAIDEN NAME First Middle Last				
Joseph Tuttle					Deborah Van Zandt				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT					
No		265-03-7748		MR. ANTON SQUILLARI, 252 W. MECHANIC ST., FROSTBURG, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, terminal								15 hours	
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									
DUE TO, OR AS A CONSEQUENCE OF									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
Cerebrovascular accident; arteriosclerotic heart disease									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (the deceased) attended the deceased from Feb. 7, 1968 , to June 3, 1969 , that (I) (we) last saw the deceased alive on June 3, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (not) view the body after death.									
22b. SIGNATURE Fe U. Porciuncula					DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 6/3/69		
22d. PHYSICIAN'S NAME (Type) Fe U. Porciuncula, M.D.					22e. ADDRESS Western Maryland State Hospital, 1500 Pennsylvania Ave., Hagerstown, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		6/6/69		FROSTBURG MEM. PARK		FROSTBURG, ALLEGANY, MD.			
24. FUNERAL DIRECTOR M. SOWERS, HAFFER-SOWERS FUNERAL HOME, 60 W. MAIN, FROSTBURG					25a. REC'D BY REGISTRAR JUN 12 1969		25b. REGISTRAR'S SIGNATURE Charles Judge		

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DEPARTMENT OF HEALTH

NAME	AGE	SEX	RACE	DATE OF BIRTH	DATE OF DEATH	PLACE OF BIRTH	PLACE OF DEATH	CAUSE OF DEATH	DIAGNOSIS	DATE OF EXAMINATION	EXAMINER
JOSEPH	45	M	WHITE	1910	1955	NEW YORK	NEW YORK	HEART DISEASE	HEART DISEASE	1955	DR. J. H. HARRIS
ALICE	35	F	WHITE	1920	1955	NEW YORK	NEW YORK	HEART DISEASE	HEART DISEASE	1955	DR. J. H. HARRIS
JOHN	25	M	WHITE	1930	1955	NEW YORK	NEW YORK	HEART DISEASE	HEART DISEASE	1955	DR. J. H. HARRIS
MARY	20	F	WHITE	1935	1955	NEW YORK	NEW YORK	HEART DISEASE	HEART DISEASE	1955	DR. J. H. HARRIS
WILLIAM	15	M	WHITE	1940	1955	NEW YORK	NEW YORK	HEART DISEASE	HEART DISEASE	1955	DR. J. H. HARRIS

Coronary atherosclerosis; myocardial infarction; heart disease

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NAME	AGE	SEX	RACE	DATE OF BIRTH	DATE OF DEATH	PLACE OF BIRTH	PLACE OF DEATH	CAUSE OF DEATH	DIAGNOSIS	DATE OF EXAMINATION	EXAMINER
JOHN	45	M	WHITE	1910	1955	NEW YORK	NEW YORK	HEART DISEASE	HEART DISEASE	1955	DR. J. H. HARRIS
MARY	35	F	WHITE	1920	1955	NEW YORK	NEW YORK	HEART DISEASE	HEART DISEASE	1955	DR. J. H. HARRIS
WILLIAM	25	M	WHITE	1930	1955	NEW YORK	NEW YORK	HEART DISEASE	HEART DISEASE	1955	DR. J. H. HARRIS
ALICE	20	F	WHITE	1935	1955	NEW YORK	NEW YORK	HEART DISEASE	HEART DISEASE	1955	DR. J. H. HARRIS
JOHN	15	M	WHITE	1940	1955	NEW YORK	NEW YORK	HEART DISEASE	HEART DISEASE	1955	DR. J. H. HARRIS

FOR STATE
HEALTH DEPT.

09092

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09083

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH ESTI- MATED <input checked="" type="checkbox"/> Month Day 1969			2b. HOUR 4.45 PM		
LEWIS			VICTOR			STOTELMYER					
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year 1969			2d. HOUR 5:20 PM
Male	White	Oct 28 1904	64 YRS					6			6
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
Maryland			U.S.A.						Washington Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Hagerstown R #4			B roadfording Road			Brick Mason			Retired		
13a. USUAL RESIDENCE (Where deceased admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
Maryland			Washington			Hagerstown			1012 Pope Ave		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
H arvey Stotelmyer			Flora Baker								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
No			214-09-3497			Alfred L. Stotelmyer			407 W. Antietam S		
						H agerstown Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Generalized Arteriosclerosis</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2-3 hrs.</u> <u>25 yrs</u>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <u>Benign Prostatic Hypertrophy</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No.			City or Town County State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED					
EXAMINER'S NAME (Type)			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			6-7-69					
EDWARD W. DITTO, III, M.D.			ADDRESS (Street, city, town, or county)			217 W. WASHINGTON ST. HAGERSTOWN, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			6/9/69			Rose Hill Cemetery			Hagerstown Wash Co Md.		
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
Hagerstown Md. ADDRESS			DATE JUN 11 1969			J Charles Judge					
Andrew K. Coffman Funeral Home Inc											

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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<div>09093</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>09084</div>									
1. DECEASED-NAME (Type or print) CATHERINE LEONA STOUFFER					2a. DATE OF DEATH JUNE Month 7 Day 1969 Year 2:45A M.				
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 8/2/1901		6. AGE (In years last birthday) 67 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH WASHINGTON Md.			
10. CITY OR TOWN OF DEATH HAGERSTOWN		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital during month of death, state where deceased died) WASHINGTON CO. HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during month of death, or while deceased if retired.) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY HOME		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) MARYLAND		13b. CITY OR TOWN WASHINGTON		13c. CITY OR TOWN SMITHSBURG		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER RT. 32 SMITHSBURG MD.	
14. FATHER'S NAME First Middle Last LUTHER KEMP MURRAY				15. MOTHER'S MAIDEN NAME First Middle Last LEAH SNYDER					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 213-16-1273		17. INFORMANT Address MR. EDWARD STOUFFER RT. 2 SMITHSBURG MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Abdominal Cramps 1950 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 mos									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o) Ischemia left kidney due to compression renal artery									
19a. DATE OF OPERATION 3/12/69		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Intestinal Obstruction		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 3/8/ 19 69 , to 6/7/ 19 69 , that (I) (we) last saw the deceased alive on 6/7 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE John A. Moran MD				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 6/9/69			
22d. PHYSICIAN'S NAME (Type) JOHN A. MORAN				22e. ADDRESS 215 W Washington St Hagerstown, Md					
23a. BURIAL, CREMATION, or other disposition of body BURIED		23b. DATE 6/10/69		23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.		23d. LOCATION (City or Town) (County) (State) HAGERSTOWN WASH. MD.			
24. FUNERAL DIRECTOR ADDRESS W. J. Norman, Hagerstown, Md.				25a. RICH BY REGISTRAR DATE JUN 11 1969		25b. REGISTRAR'S SIGNATURE Richard Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) First Middle Last Mary Esta Suffecool						2a. DATE OF DEATH Month Day Year June 14, 1969			2b. HOUR M		
3. SEX female		4. RACE white		5. DATE OF BIRTH Nov. 8, 1900		6. AGE (In years last birthday) 68 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington Md.					
10. CITY OR TOWN OF DEATH Hagerstown			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Wash. Co. Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) housewife			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE Md.			13b. COUNTY Wash.		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 14 Walnut St.		
14. FATHER'S NAME First Middle Last John Westerberger				15. MOTHER'S MAIDEN NAME First Middle Last Emma Kline							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no				16b. SOCIAL SECURITY NO. 219-20-0364		17. INFORMANT Address Willard Suffecool Hagerstown, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarct 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary Emboli multiple weeks. (c) Cerebral thrombosis 3 weeks.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hours	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) diabetes mellitus											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State 5-28 69 6-14 69							
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 6-13-1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE David J. Boyer				DEGREE ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 6-16-69			
22d. PHYSICIAN'S NAME (Type) David J. Boyer				22e. ADDRESS 136 N. Potomac St. Hagerstown, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 6-17-69		23c. NAME OF CEMETERY OR CREMATORY St. Paul's Cemetery		23d. LOCATION (City or Town) (County) (State) Clear Spring, Md.					
24. FUNERAL DIRECTOR Minnich Funeral Home Hagerstown, Md.				ADDRESS		25a. REC'D BY REGISTRAR DATE JUN 18 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

09095

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09086

1. DECEASED-NAME (Type or print)			First LENA	Middle PEARL	Last SUNDERLAND	2a. DATE OF DEATH Month Day Year JUNE 12 69			2b. HOUR 1:15aM			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MARCH 8, 1891		6. AGE (In years last birthday) 78 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) DELAWARE		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH WASHINGTON			Md.			
10. CITY OR TOWN OF DEATH HAGERSTOWN			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 1011 OAK HILL AVENUE			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) RETIRED NURSE			12b. KIND OF BUSINESS OR INDUSTRY NURSING			
13a. USUAL RESIDENCE (Where deceased admission) STATE MARYLAND			13b. COUNTY WASHINGTON			13c. CITY OR TOWN HAGERSTOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1011 OAK HILL AVENUE		
14. FATHER'S NAME First Middle Last WILLIAM EDGAR BRYAN			15. MOTHER'S MAIDEN NAME First Middle Last ANNIE CAHALL									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) NO			16b. SOCIAL SECURITY NO. (If yes give war or dates of service)			17. INFORMANT JOHN SUNDERLAND						
						Address 1011 OAK HILL AVENUE HAGERSTOWN, MARYLAND						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cancer of breast & generalized metastases</i> 174X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cancer of breast</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>1955</i>											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Hypertensive cardiac D.S. Underminatory</i>												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (the deceased) attended the deceased from <i>3504</i> , 19 <i>69</i> , to <i>date</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>June 11</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>Richard T. Binford</i>						DEGREE ATTENDING PHYS.		<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 6/13/69		
22d. PHYSICIAN'S NAME (Type) RICHARD T. BINFORD						22e. ADDRESS 1135 POTOMAC AVE., HAGERSTOWN, MD.						
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE 6/15/69		23c. NAME OF CEMETERY OR CREMATORY REST HAVEN CEMETERY			23d. LOCATION (City or Town) (County) (State) HAGERSTOWN WASHINGTON, MD				
24. FUNERAL DIRECTOR <i>Charles M. Renger</i>						ADDRESS HAGERSTOWN, MARYLAND		25a. REC'D BY REGISTRAR DATE JUN 17 1969		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

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TO THE DIRECTOR, FBI, WASHINGTON, D.C.

FROM THE SAC, NEW YORK (100-100000)

SUBJECT: [Illegible]

RE: [Illegible]

DATE: 3/24/51

TO: [Illegible]

FROM: [Illegible]

SUBJECT: [Illegible]

RE: [Illegible]

DATE: 3/24/51

TO: [Illegible]

FROM: [Illegible]

SUBJECT: [Illegible]

RE: [Illegible]

DATE: 3/24/51

TO: [Illegible]

FROM: [Illegible]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
09096					CERTIFICATE OF DEATH			09087			
1. DECEASED-NAME (Type or print)			First	Middle	Lost	2a. DATE OF DEATH			2b. HOUR		
Irene Melva Thayer						6 Month 28 Day 69 Year			M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN			
female		white		Feb. 11, 1910		39 YRS.					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Md.		USA				Washington Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Hagerstown			29 E. Irvin Ave.			housewife					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
Md.			Wash.		Hagerstown		YES		29 E. Irvin Ave.		
14. FATHER'S NAME			First	Middle	Lost	15. MOTHER'S MAIDEN NAME			First	Middle	Lost
Edward Smouse						Anna Murphy					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT Address					
No						Ralph Thayer Hagerstown, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple sclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>340 X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>17 years.</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>1952</u> , to <u>June 28, 1969</u> , that (I) (we) last saw the deceased alive on <u>June 21, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>A. S. Stauffer</u>			M.D. DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>June 30, 1969</u>		
22d. PHYSICIAN'S NAME (Type) <u>R.S. STAUFFER</u>			22e. ADDRESS <u>Hagerstown, Md.</u>								
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
burial		7-1-69		Oakland Cemetery			Oakland, Md.				
24. FUNERAL DIRECTOR ADDRESS					25. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE				
Minnich Funeral Home Hagerstown, Md.					JUL 3 1969		<u>[Signature]</u>				



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4450

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
09097					CERTIFICATE OF DEATH					09088							
1. DECEASED-NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH			2b. HOUR					
Richard			Harry		Troxell Sr.		June 12 1969										
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.				
Male			White			March 5, 1905			64		MONTHS		DAYS				
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH								
Hagerstown, Md.			USA						Washington								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY								
Hagerstown			Washington Co. Hospital			Self Employed			Tavern								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER					
Maryland			Washington			Hagerstown			YES			211 West Side Ave.					
14. FATHER'S NAME			First		Middle		Last		15. MOTHER'S MAIDEN NAME			First		Middle		Last	
William			R		Troxell		Etta			Mae			French				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown			(If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address					
No						214-09-1213			R.H. Troxell Jr.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gangrene of left lower extremities</u> <u>4450</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Advanced arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
												Days					
												Years					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)										
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No.			City or Town		County		State			
22a. I certify that (I) this hospital attended the deceased from <u>1/17/69</u> , to <u>6/12/69</u> , that (I) xxx saw the deceased alive on <u>6/12/1969</u> , and that in (my) our opinion death occurred on the date and hour and from the causes stated above, (I) xxx (did not) view the body after death.																	
22b. SIGNATURE <u>Howard N. Weeks</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. DATE SIGNED <u>6/13/69</u>																	
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS											
Howard N. Weeks						580 Northern Ave., Hagerstown, Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town)			(County)		(State)				
Burial			6/14/69		Rest Haven Cemetery			Hagerstown-Washington-Md.									
24. FUNERAL DIRECTOR <u>Wm. C. Horst</u>						25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE								
Rest Haven Funeral Chapel Hagerstown, Md.						DATE 1 7 1969			<u>Richard H. Under</u>								

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) LEROY FRANKLIN TRUE						2a. DATE OF DEATH Month JUNE Day 26 Year 1969			2b. HOUR 9:30 AM		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH DEC. 11, 1911			6. AGE (In years last birthday) 57 YRS.		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH WASHINGTON Md.					
10. CITY OR TOWN OF DEATH HANCOCK			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) RFD #2			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) SERVICE MANAGER			12b. KIND OF BUSINESS OR INDUSTRY AUTO		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND				13b. COUNTY WASHINGTON		13c. CITY OR TOWN HANCOCK		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER RFD #2	
14. FATHER'S NAME First Middle Last JOHN WESLEY TRUE				15. MOTHER'S MAIDEN NAME First Middle Last IRENE ADA SPADE							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO (If yes give war or dates of service)				16b. SOCIAL SECURITY NO. 213 03 4634		17. INFORMANT Address DOROTHY S. TRUE RFD #2, HANCOCK, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 4109 DUE TO, OR AS A CONSEQUENCE OF Rheumatic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 min 50 yrs.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 5/14/69 , 19 69 , to 6/26/69 , 19 69 , that (I) (we) last saw the deceased alive on 5/14/69 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE FB Thomas III M.D. DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED 6/27/69					
22d. PHYSICIAN'S NAME (Type) FB Thomas III M.D.						22e. ADDRESS Hancock, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 6/28/69		23c. NAME OF CEMETERY OR CREMATORY CEDAR LAWN MEMORIAL				23d. LOCATION (City or Town) (County) (State) HAGERSTOWN, WASH. MD.			
24. FUNERAL DIRECTOR Richard J. Shaw Hancock, Md.						25a. REC'D BY REGISTRAR DATE JUL 1 1969		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

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IRENE ADA SPAD

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GEORGE LAMM MEMORIAL

WASHINGTON, WASH. D.C.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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09099		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				09090	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH	
LAURA			BESSIE	VALENTINE	JUNE	Month 5 Day 1969 Year	2b. HOUR 3P.M.
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)	
FEMALE		WHITE		7/24/1889		79 YRS.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
MARYLAND		U.S.A.		WASHINGTON		Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
MAUGANSVILLE		MENNONITE HOME		HOUSEWIFE		HOME	
13a. USUAL RESIDENCE (Where deceased admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
MARYLAND		WASHINGTON		HAGERSTOWN		729 SUMMIT AVE.	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME	
MARTIN			BAKER	ESTHER	WILLIMSON		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT		
NO			NONE		MRS. ESTHER R. WHITLOW MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) Coronary occlusion							Sudden
DUE TO, OR AS A CONSEQUENCE OF							
(b) Hypertensive arteriosclerotic heart							Years
DUE TO, OR AS A CONSEQUENCE OF							
disease							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
					YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
		HOUR A.M. Month Day Year					
		P.M. 19					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (we) attended the deceased from 2/17, 1964, to 6/5, 1969, that (I) (we) last saw the deceased alive on 4/28, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE				DEGREE		22c. DATE SIGNED	
Howard N. Weeks, M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		6/6/69	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS			
				580 Northern Ave., Hagerstown, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
BURIAL		6/7/69		ROSE HILL CEM.		HAGERSTOWN WASH. MD.	
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
W. J. Korman, Hagerstown, Md.				JUN 10 1969		Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR	
ORPHA			RUTH			JUNE		Month 6 Day 1969 Year	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
FEMALE		WHITE		9/8/1895		73 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
MARYLAND		U.S.A.				WASHINGTON Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
HAGERSTOWN		306 W. WILSON BLVD.		HOUSEWIFE		HOME			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
MARYLAND		WASHINGTON HAGERSTOWN				306 W. WILSON BVD.			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
IVERSON S. JONES			SARAH HAUSE						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT					
NO		214-09-7191		MRS ALICE REECHER		HAGERSTOWN MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) 4100								1 1/2 hours	
DUE TO, OR AS A CONSEQUENCE OF									
(b) Hypertensive CV Dis								15 years	
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 1-15, 1969, to 6-6, 1969, that (I) (we) last saw the deceased alive on 6-4, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Robert P. Conrad, MD				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 6-9-69			
22d. PHYSICIAN'S NAME (Type) Robert P. Conrad, MD				22e. ADDRESS 137 W. Washington Hagerstown, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		6/10/69		REST HAVEN CEM.		HAGERSTOWN WASH. MD.			
24. FUNERAL DIRECTOR W. J. Norment, Hagerstown, Md.				25a. REC'D BY REGISTRAR JUN 13 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

00190

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

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FOR STATE
HEALTH DEPT.

09101

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09092

1. DECEASED-NAME (Type or Print)		First ERNEST		Middle EDWIN		Last WOLFENBERGER		2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> JUNE 19 19 69		2b. HOUR 5:20 M	
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH 1/26/1907		6. AGE (In years last birthday) 62 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD Month Day Year JUNE 19 19 69	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH WASHINGTON				Md.	
10. CITY OR TOWN OF DEATH HAGERSTOWN		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WASHINGTON CO. HOSPITAL				12a. USUAL OCCUPATION (Kind of work done during major part of time, if even if retired) MECHANIC		12b. KIND OF BUSINESS OR INDUSTRY AUTO GARAGE			
13a. USUAL RESIDENCE (Where deceased admission) MARYLAND		13b. COUNTY WASHINGTON		13c. CITY OR TOWN MAUGANSVILLE		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER BOX 8			
14. FATHER'S NAME First Middle Last CHARLES WOLFENBERGER				15. MOTHER'S MAIDEN NAME First Middle Last CRISTI ANNA SHOWALTER							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		16b. SOCIAL SECURITY NO. (If yes on war or dates of service) W.W.#2 215-10-2271		17. INFORMANT MR. HARRY W. WOLFENBERGER				ADDRESS RT#3 HAGERSTOWN MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion, Old and Recent DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 4109 (b) Myocardial Infarction, Healed DUE TO, OR AS A CONSEQUENCE OF (c) Cardiac Hypertrophy										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Recent	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Dr. E. W. Ditto, Jr.		EXAMINER'S NAME (Type)		22b. DATE SIGNED 6-20-69		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 6/21/69		23c. NAME OF CEMETERY OR CREMATORY CEDAR LAWN MEM. PARK		23d. LOCATION (City or Town) (County) (State) HAGERSTOWN WASH. MD.					
24. FUNERAL DIRECTOR W. J. Norment, Hagerstown, Md.		ADDRESS		25a. REC'D BY REGISTRAR JUN 24 1969		25b. REGISTRAR'S SIGNATURE J. Charles Judge					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death
necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. (Give Pages 1, 2, and 3 to
the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page
5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of
Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR INFO
NOTES

RECEIVED
MAY 19 1968

TO: DIRECTOR, FBI
FROM: SAC, NEW YORK (100-100000)

SUBJECT: [Illegible]

RE: [Illegible]

DATE: [Illegible]

BY: [Illegible]

100-100000

[Illegible]

[Illegible]

100

100

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

09102		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				09093			
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First	Middle	Lost	2a. DATE OF DEATH Month Day Year			
Margaret			Salome	Yeakle		June 22 1969			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)			
Female		White		February 4, 1909		60 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Washington Co. Md.		USA				Washington Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Hagerstown		109 Randolph Ave.		Housewife		Own Home			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
Maryland		Washington		Hagerstown		13e. STREET AND NUMBER			
						109 Randolph Ave.			
14. FATHER'S NAME			First	Middle	Lost	15. MOTHER'S MAIDEN NAME			
George			Washington	Grimes		Pearl Nettie Wolford			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT				
No			212-24-6113		Mr. A.D. Yeakle 109 Randolph Ave. Hagerstown, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic carcinoma to lung</u>						1 yr.			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						(b) <u>Carcinoma of Kidney</u>			
						(c)			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>Jun</u> , 19 <u>67</u> , to <u>Jun 22</u> , 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>16 Jun</u> 19 <u>67</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Eldon S. Hoachler</u> DEGREE <u>MD</u> ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED <u>6/23/69</u>			
22d. PHYSICIAN'S NAME (Type) <u>Eldon S. Hoachler</u>						22e. ADDRESS <u>Hagerstown Md</u>			
23a. BURIAL, CREMATION, REMOVAL <u>Burial</u>		23b. DATE <u>6/25/69</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Hagerstown-Washington-Md.</u>			
24. FUNERAL DIRECTOR <u>Wm. G. ...</u> ADDRESS <u>Rest Haven Funeral Chapel Hagerstown, Md.</u>				25a. RECD BY REGISTRAR <u>JUN 26 1969</u> DATE		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

90720

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

09103

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09094

1. DECEASED-NAME (Type or Print)		First	Middle	Last	2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 6 3 1969		2b. HOUR 2:00 PM
Hattye		Cochran		Yourtee			
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD Month Day Year	2d. HOUR
female	white	2-10-1887	82 YRS.			6 3 1969	7:45 PM
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
Md.		USA				Washington	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Hagerstown		1853 Virginia Ave.		housewife			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Md.		Wash.		Hagerstown		1853 Virginia Ave.	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		17. INFORMANT	
Clifford		Cochran		Cora		Stockman	
16a. SOCIAL SECURITY NO.		17. ADDRESS		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fractured Skull & Brain</u> 880 X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Stomach Damage</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic Vascular Disease - severe</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>	
212-30-4466A		Helen Cochran		Hagerstown, Md.			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR <u>PM</u> 6:13 1969		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <u>Fell Down Basement Stairs</u>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <u>Home</u>		21f. LOCATION Street or R.F.D. No. City or Town County State <u>1853 Virginia A. Hagerstown Md</u>			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Edward W. Ditto</u>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <u>6-3-69</u>	
EXAMINER'S NAME (Type) EDWARD W. DITTO, III, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		217 W. WASHINGTON ST. HAGERSTOWN, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
Burial		6-5-69		Reformed Cemetery		Jefferson, Md.	
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR DATE JUN 9 1969		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
Minnich Funeral Home Hagerstown, Md.							

HEALTH DEPT

00103

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00000

Name of Deceased		John Doe	
Sex		Male	
Age		45	
Date of Birth		1910-10-15	
Place of Birth		New York, N.Y.	
Usual Residence		123 Main St., New York, N.Y.	
Cause of Death		Heart Disease	
Manner of Death		Natural	
Signature of Medical Examiner		[Signature]	
Date of Examination		1955-10-20	
Place of Examination		New York, N.Y.	
Signature of Coroner		[Signature]	
Date of Issuance		1955-10-20	
Place of Issuance		New York, N.Y.	

NEW YORK, N.Y.

EDWARD J. GITT, M.D.

Medical Examiner, New York City

1955 10 20

4109

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09104

CERTIFICATE OF DEATH

09095

1. DECEASED-NAME (Type or print) GEORGE JUNIOR ZIMMERMAN			2a. DATE OF DEATH Month JUNE Day 27 Year 1969			2b. HOUR M 				
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH AUGUST 30, 1923		6. AGE (In years last birthday) 45 YRS.		IF UNDER 1 YEAR MONTHS DAYS 		
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH WASHINGTON Md.				
10. CITY OR TOWN OF DEATH WILLIAMSPORT			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) RURAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) POTOMAC EDISON			12b. KIND OF BUSINESS OR INDUSTRY POWER PLANT	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND			13b. COUNTY WASHINGTON		13c. CITY OR TOWN WILLIAMSPORT		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 204 S. ARTIZAN STREET	
14. FATHER'S NAME First Middle Last EARL T. ZIMMERMAN			15. MOTHER'S MAIDEN NAME First Middle Last GRACE M GARRISH			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) YES (If yes give war or dates of service) W.W. 2				
16b. SOCIAL SECURITY NO. 215 14 2585			17. INFORMANT LARUE T. ZIMMERMAN			204 S. ARTIZAN ST. WILLIAMSPORT, MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 min										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) none										
19a. DATE OF OPERATION 		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. _____ Month _____ Day _____ Year _____ P.M. _____		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) 						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) 		21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____						
22a. I certify that (I) (as a physician) attended the deceased from 5.9. , 19 58 , to 6.27 , 19 69 , that (I) (we) last saw the deceased alive on _____ 19 _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE M.E. Byrkit M.D.				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 6.30.69				
22d. PHYSICIAN'S NAME (Type) M.E. Byrkit M.D.				22e. ADDRESS 28 W. Potomac St. Williamsport Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 6/30/69		23c. NAME OF CEMETERY OR CREMATORY GREEN LAWN			23d. LOCATION (City or Town) (County) (State) WILLIAMSPORT WASH., MD.			
24. FUNERAL DIRECTOR Howard J. Stone Williamsport, Md.				25a. REG'D BY REGISTRAR JUL 2 1969		25b. REGISTRAR'S SIGNATURE 				

30100

JUNE 27, 1989

ZIMMERMAN

JUNIOR

GEORGE

AUGUST 30, 1923

WHITE

MALE

WASHINGTON

U.S.A.

MARYLAND

WILLIAMSPORT

RURAL

POTOMAC EDITION

204 S. ARTIZAN STREET

WILLIAMSPORT

WASHINGTON

MARYLAND

EARL

T. ZIMMERMAN

GRADE

N. GARRISON

YES

W.W.

512 W 5285 LARUE T. ZIMMERMAN

WILLIAMSPORT, MD.

GREEN LAWN

6/30/89

BURIAL

WILLIAMSPORT WASH. MD.